The Public Health Nurse

Volume XVII March, 1925 Number 3

First Complete State Census—Rhode Island

The PUBLIC HEALTH NURSE

Official Organ of The National Organization for Public Health Nursing

Volume XVII | MARCH, 1925 | Number 3

EDITORIAL

MISS NUTTING'S RESIGNATION

The name of Adelaide Nutting is so associated with Teachers College that it is with something of a shock that we learn that Miss Nutting has tendered her resignation as Professor of the Department of Nursing and Health, and that at the close of this academic year she will leave the College she has served for so many years. Yet there should be no shock in such an announcement as this. Miss Nutting's long years of service have borne the fruit that she is justified in expecting and if ever woman earned the right to lay down the tools of daily demanding toil, it is she.

A member of the first class to enter the Johns Hopkins Training School in 1889, Miss Nutting has carried the burden of important nursing work for more than thirty years; indeed since 1894, when as a young graduate of only three years' standing she succeeded Mrs. Robb as Superintendent of the Johns Hopkins Training School. In those early days of nursing development—the struggles and difficulties of which are almost forgotten by nurses of to-day—there were few, if any, progressive movements in which Miss Nutting did not take a leading part. Should history be unfolded in all its detail nurses of to-day would discover that many of the opportunities and privileges of their profession, now so easily accepted by them as matters of course, are in fact a direct result of Miss Nutting's far-seeing wisdom, and undaunted courage—for statesmanship, vision, unusual practical ability and a power of hard work astonishing to less vigorous mortals have always set her apart as that rare thing, a great leader.

Public health nurses especially owe much to Miss Nutting. The course in Public Health Nursing offered in her department has a more than national reputation, attracting to the College

students not only from every state in the Union, but from many of the foreign countries.

Miss Nutting will be missed from her chair at the College, and perhaps from active participation in the important committee work with which we so associate her name, but her going leaves no unfilled gaps or unprepared-for vacancies. Miss Isabel Stewart, long associated with her in her College work, is to be her successor, and in her hands we may be assured that there will be no change in the high standing of the Department. Nor is the nursing profession losing Miss Nutting. Long may she live to continue generously to share with us the results of her years of experience and the knowledge gained by thirty years spent at the very heart and center of nursing affairs.

MARY S. GARDNER

TO BE OR NOT TO BE

The Finance Committee and the Extension Secretary have been cudgelling their brains. They have cudgelled and cudgelled and now they need more brains—YOUR brains—to build up, from a tentative plan of their making, a sound structure of financial support to the N.O.P.H.N.

For twelve years the major part of our income has come from voluntary contributions. Generous grants from the Foundations and the American Red Cross have tided us over the "dangerous age" of pioneering. Now these large donors feel that the Public Health Nursing movement is sufficiently solidified to support its own National Organization and they must withdraw their support.

It is the part of wisdom, then, to take stock of our strength. These twelve years have been spent in building up the machinery and acquiring the experience to render certain services for the sound promotion of public health nursing; services that can effect for local associations improvement in methods and improvement in the quality and quantity of personnel. The N.O.P.H.N. must live now by the value of these services to local associations. "To be or not to be: that is the question," and we look to you for the answer.

That you may weigh carefully all the facts in the case, the Finance Committee and the Extension Secretary have prepared, together with a brief "Outline of History" of the N.O.P.H.N., a plan for financing the Organization. They now need YOUR brains to build up, from the basis of this plan for securing financial support, one that is sounder and better.

Send for the pamphlet, **To Be or Not To Be**, and give us the benefit of your constructive help and criticism on this tentative plan for the future support of the N.O.P.H.N.

THE CHILD LABOR AMENDMENT

Up-to-date Facts

EDITOR'S NOTE: Since the article by E. N. Mathews on *The Children's Amendment* appeared in the January issue, the amendment has come up before many state legislatures. Inquiries have come to us as to the actual status of the amendment at the present moment. We are glad to have the privilege of printing Mrs. Florence Kelley's succinct account of the situation to-day.

THE volume and character of misrepresentations of the federal child labor Amendment have delayed ratification. Opponents are broadcasting the unfounded statement that because 21 legislatures have voted against it, in one or both Houses, the Amendment is a dead issue. It is, therefore, the duty of friends of the Amendment to give publicity to these current facts.

Far from being over, the struggle for ratification has hardly begun. It will continue until 36 states have ratified by a majority vote of their legislatures. No other method of ratification is possible while we live under Article V of the present Constitution. The child labor Amendment must have the same legislative approval now that its 19 predecessors have had in the last 135 years. No state referendum can take the place of majority action by each one of 36 legislatures.

Opponents neglect to state five important items, *e.g.:*

1. Eleven of the twenty-one states have voted in one House only.
2. The whole eleven, or the whole twenty-one, can reverse themselves and vote *for.*
3. Only a state that has voted for, can *not* reverse its action.
4. Five of the ten states which have voted against in both Houses are Southern—Delaware, Georgia, North and South Carolina, Texas. Georgia refused in 1924 to amend its state child labor law.
5. *There is no time limit for ratification.* A federal amendment in process of ratification has more lives than a cat.

Four states, Arizona, Arkansas, California and Wisconsin, have ratified in both Houses. This action is final. They can never reconsider. Three more have ratified each in one House, Montana, New Mexico and Oklahoma.

The most widespread objection is that the Amendment will prohibit all boys and girls from working until their eighteenth birthdays. *But the Amendment prohibits nothing whatever.* It gives Congress a power that Congress and the people always believed that it had, until the Supreme Court by 5 to 4 decided that Congress had not.

Every state has power to prohibit the labor of persons below the age of 21 years. The Amendment gives Congress less power than New York always had, and wisely uses.

New York is among the most enlightened of the states. For many years it has prohibited the delivery of messages and telegrams by boys under 21 years of age between 10 P.M. and 6 A.M. In 1917, in this State, 1,983 boys and girls under 18 years old were injured sufficiently to receive workmen's compensation. Not one other state, then or since, has published the number of young people, below the age of 18 years, killed and injured in industry in any one year.

Alone among great industrial peoples Americans leave the duty of compelling employers to safeguard life and limb of their minor employees to governmental power less than the national Congress.

FLORENCE KELLEY.

N.O.P.H.N. FINANCIAL STATEMENT FOR 1924

Based on Auditor's Report

INCOME

MEMBERSHIP DUES			
Individual Members			
4813 Nurse and Associate Nurse	$14,439.00		
710 Sustaining	3,550.00		
		$17,989.00	
CORPORATE MEMBERS			
31 corporate and Associate Corporate at $25.00	$775.00		
184 Corporate and Associate Corporate at $10.00	1,840.00		
34 Sustaining Corporate	170.00		
		$2,785.00	
			$20,774.00
CONTRIBUTIONS			
169 General Contributions		$37,137.65	
39 Nurse Contributions		330.20	
1 Sustaining Member for Convention Exhibit expense		144.39	
			37,612.24
APPROPRIATIONS			
1 From Foundation		$5,000.00	
2 From Community Chests		2,450.00	
			7,450.00
MAGAZINE REVENUE			
Direct subscriptions		$2,925.05	
Sales of single copies		116.52	
Advertisements		8,010.70	
			11,052.27
MISCELLANEOUS SOURCES			
Royalties on forms		$194.69	
Rental of films		48.00	
Sale of films		230.00	
Sale of pins		374.32	
Sale of reprints		457.91	
Sale of publicity material		319.02	
Sale of vocational forms		21.16	
Bank interest		112.41	
Discounts taken		1.43	
Refunds—foreign postage		94.37	
Convention exhibit space		348.57	
			2,201.88
Sale of services			3,615.52
Total income applicable to regular activities			$82,705.91
FUNDS FOR SPECIAL ACTIVITIES			
American Child Health Association Nursing Division		$10,584.14	
Convention publicity		600.00	
Committee to Study Visiting Nursing		2,666.64	
Financial Study Fund		2,500.00	
			16,350.78
Total income			$99,056.69

EXPENSE

Administration	$10,643.50	
Affiliated memberships and Health Council dues	1,065.00	
Educational propaganda	249.12	
Participation in exhibits	11.31	
Travel—representation	201.67	
Scholarship possibility	0.00	
Convention	2,270.17	
Accounting service	2,965.89	
Committee and Section activities	842.52	
Magazine	26,536.16	
Advisory service	6,005.95	
Educational	6,924.08	
Eligibility	3,537.72	
Field	5,965.61	
Membership	4,580.28	
Publicity advice	1,769.81	
Statistical	7,191.71	
Library	4,155.98	
Child health nursing	10,643.50	
Vocational	8,578.29	
Pin service and sales	685.14	
Film service and sales	838.19	
Reprint service and sales	1,957.76	
Publicity material service and sales	1,310.15	
Committee to Study Visiting Nursing	2,666.64	
Convention publicity	600.00	
Special committee	66.81	
Financial Study Fund	374.71	
Total expense		$112,637.67

ASSETS

CASH:			
General Fund	$2,992.91		
Emergency Fund	1,000.00		
Committee to Study Visiting Nursing	364.17		
		$4,357.08	
ACCOUNTS RECEIVABLE		1,130.99	

INVENTORY: ASSETS (*Continued*)			
Brought forward		$5,488.07	
Reprints, pins, publicity material, back copies of magazines	$800.62		
Films, negatives and prints	415.00		
Furniture and equipment	3,089.40		
		4,305.02	
Total assets			$9,793.09
LIABILITIES			
Advances payable—study of visiting nursing		$364.17	
Accounts payable		261.16	
Loans payable		7,000.00	
Accrued interest payable		35.00	
Prepaid subscriptions to magazine		1,530.25	
Total liabilities		$9,190.58	
Deferred income—pending items		615.95	
			$9,806.53
Deficit in General Fund			13.44
Cash applicable to Financial Study Fund			2,125.29
Net asset value			$2,111.85

BUDGET FOR 1925

AN ESTIMATE OF GROSS EXPENDITURES

1. Rent, light, heat	$5,744.60	
2. Office service and supplies	3,100.00	
3. Telephone	770.00	
4. Telegraph	250.00	
5. Accounting	2,750.00	
6. Postage	2,000.00	
7. Equipment	356.50	
8. Affiliated memberships	1,055.00	
9. Reprints for resale	300.00	
10. Films for resale	200.00	
11. Pins for resale	00.00	
12. Publicity material for resale	275.00	
13. Educational propaganda	243.00	
14. Participation in exhibits	50.00	
15. Library	4,240.00	
16. Magazine	12,810.00	
17. Addressograph service	600.00	
18. Multigraph service	500.00	
19. Travel	13,150.00	
20. Salaries	60,242.00	
Gross budget		$108,636.10
Less Expected Refunds, Resales and Special Appropriations		
Magazine—Advertisements	$7,000.00	
Subscriptions	2,000.00	
Reprints	300.00	
Films—Sales and rentals	250.00	
Publicity material	300.00	
	$9,850.00	
Special appropriation—A.C.H.A.	19,980.00	
		29,830.00
Net budget		$78,806.10

It is estimated that each project will cost approximately the following amounts:

Administration	$12,846.69	
Accounting	3,122.00	
Equipment	356.50	
Affiliated memberships	1,055.00	
Educational propaganda	243.00	
Participation in exhibits	50.00	
Travel for representatives at meetings	500.00	
Project I—State Organization	7,554.00	
Project II—Education for Public Health Nursing	9,721.57	
Project III—Vocational	9,417.12	
Project IV—Clearing House (Statistical)	6,658.25	
Project V—Advisory Service:		
General	$8,657.65	
A. Film service and sales	305.00	
B. Reprint service and sales	722.28	
C. Publicity material	344.00	
D. Library	4,240.00	
	14,268.93	
Project VI—Child Health Nursing	14,386.00	
Project VII—Magazine:		
A. Preparation	$7,837.27	
B. Printing	8,200.00	
C. Distribution	881.00	
D. Subscription	3,092.03	
E. Advertising	5,109.95	
	25,120.25	
Project VIII—Membership	3,336.79	
Total gross budget		$108,636.10

THE SIXTH WARD NURSING SERVICE OF MINNEAPOLIS

An Experiment in Generalized Nursing

By RUTH H. KING
Supervisor of the Demonstration

GENERALIZED nursing has its ardent advocates, its earnest opponents. Wherever public health workers meet, this is the topic which arouses the greatest interest and calls forth the liveliest discussion. Nobody yet knows a great deal about it. None of us will for some years to come. Certainly a two year demonstration cannot hope to prove much. It is worth reviewing in that it was unique in several respects.

In April, 1922, an article in THE PUBLIC HEALTH NURSE by Miss Ross of the Visiting Nurse Association in New Haven stimulated interest in all parts of the country, for three years ago generalized nursing was a rather new term. To this article, "A Field Study of Generalized and Specialized Nursing," Minneapolis owes its own little demonstration. The New Haven figures showed that one-fifth of the work has been done by the demonstration nurses, though only one-sixth of the nurses of the organization were on duty in the special district. The article stressed the fact that quality was in no way sacrificed, but had been safeguarded by a system of specialized supervision. The sponsors of the Sixth Ward Nursing Service decided to follow the New Haven plan so far as local conditions would permit, to find out if Minneapolis could effect an equal saving and keep high standards of work. The demonstration showed, as have all others, that in generalized nursing more intensive work is not only possible, but inevitable. So five visits were made in sixth ward families for every two in families in the rest of the city. Saving, then, is not actual but comparative under generalized nursing; the health budget will probably have to be increased rather than cut down when Minneapolis generalizes all its health work. Quality is more difficult to measure than quantity; as will be shown later, standards were maintained if not actually raised.

The Plan

The plan was not at all elaborate, one might call it almost naïve in that its sponsors at first decided upon eight months as the demonstration period. The coöperation of the Board of Education, the Health Department, the Visiting Nurse Association, and the Infant Welfare Society meant the inclusion of the entire school nursing, tuberculosis, visiting nursing and infant welfare programs in the demonstration area. The only nurses going into the homes, therefore, were to be the demonstration nurses.[1] No funds were available for a survey to determine the district, or to find out the exact population by age groups in the ward chosen. The section was well known, however, to every social and health agency in the city, as having the most problems, the worst housing situations, the largest number of racial groups in Minneapolis. The plan for financing the demonstration was also simple. The Board of Education offered a pleasant room in a school building with light, heat, janitor service and much of the necessary furniture, and agreed to pay the salaries of

NOTE 1.—As in French all rules have exceptions, so had this rule in practice. In the sixth ward, health department nurses placarded for communicable diseases as they did in all parts of the city. Industrial nurses and nurses representing the Veterans' Bureau were, very rarely, active in some of our families. Coöperation was excellent and in no case did the duplicate visiting seem to be a factor in the success or failure of the generalized nurse's work in the home. Duplicate visits by nurses of the tuberculosis division of the health department were less fortunate and some better method of supervision would certainly have been agreed upon had the demonstration continued.

two staff nurses. The Infant Welfare Society and The Visiting Nurse Association jointly paid the salaries of supervisor, two staff nurses and clerk. A typewriter and desk were loaned by the Red Cross. Each coöperating agency furnished all equipment necessary for its own work, including record forms. The supervisor then merely requisitioned the appropriate organization for whatever she might need. That this financial system had its disadvantages will be obvious to all supervisors with more experience than the novice who undertook to guide the Sixth Ward Nursing Service. Some of these difficulties will be taken up in more detail.

The Sixth Ward Nursing Service at Work

The sixth ward of Minneapolis has approximately 12,000 people. From October, 1922, until September, 1924, the Sixth Ward Nursing Service, sponsored by the Hennepin County Public Health Association—a group of professional and lay people representing all the health agencies of the city—and administered by the nursing committee of that association, served the sixth ward. The committee included the executive head of each component organization,

The Visiting Nurse Association
The Infant Welfare Society
The School Nursing Division of the Board of Education
The Tuberculosis Division of the Health Department

and to these executives the supervisor was directly responsible for all the work of the Service. The nurses chosen for the demonstration were each thoroughly familiar with at least one of the four types of nursing, and were given to the demonstration because they were considered especially well fitted for pioneer work. Two had had public health courses; all were given short, intensive training in the least familiar branches. The executive head of each coöperating organization, or in some cases her assistant, was the "specialist" to whom the demonstration staff turned for advice, and with whom frequent staff conferences were held. In the first few months, these conferences were many, ten in the first six weeks. As time went on and the staff became more familiar with all the details of the work, conferences were less frequent, but, always considered essential to the success of the program, were continued through the two years.

The demonstration was at first planned for only eight months. For that reason it seemed unnecessary, and

Form 2

Sixth Ward Nursing Service
DAILY REPORT

Nurse_____ **Date**_____

Section _____

NAME	ADDRESS	O. N. D.	TIME: In Travel	TIME: In Home	V. N. A.: General	V. N. A.: Prenatal	V. N. A.: Postnatal	V. N. A.: Communicable D.	I. W. S.: Regis. Baby	I. W. S.: Nonregis. Baby	I. W. S.: Expression T.	I. W. S.: Pre-School	S.S.: Absentee	S.S.: Follow-Up	T.B.: Tuberculosis	Reference	Tel. Consult.	Not Found	Car Fares
TOTAL																			

TOTAL CALLS_____

Time in Class_____
Time in Staff Meeting_____
Time in Office_____

Time in School Inspections _____
Time in Infant Welfare Clinic_____
Time in Tuberculosis Clinic_____

O Pt. to Dispensary

X Nursing / Instructive

NEO Old Discharged

much too expensive to launch the experiment with a record system of its own. Each organization supplied the sixth ward with all the forms used by that organization. They were of all sizes and shapes, requiring various files and boxes. The family folder plan, so essential to the best family case work, could not be used. The school physical record cards were filed as much for the convenience of the school principal as for the school nurse in all the city schools. To distribute these cards in family folders in four different boxes on the desks of the four nurses, did not seem a good way of establishing a friendly contact with the principal. "Birth List" cards had to be kept together and the box containing them carried twice a week to clinic so that notes of home visits could be copied from the cards to the registered baby's permanent record. And so with the tuberculosis work, the usual record was kept so that on transfer of the patient from the district, or on discharge, his record could be filed in City Hall with those from other parts of the city. This tuberculosis record was much larger than any other used. The V.N.A. family folder gave an opportunity to indicate by checks what members of the family had records in the office, and in which file. Various other forms of cross index were attempted but were discontinued. The committee for the Sixth Ward Nursing Service several times considered the possibility of giving the generalized district its own record system. However a printed daily report was the only change made during the two years.

This system, or lack of it, while trying and wasteful of time, had one advantage. It has been possible to compare the work by services with that of each organization represented. A daily time sheet made it possible to report at the end of the month the number of visits by services, so that at any time the total number of visits and their distribution was known and could be compared figure by figure with those of each coöperating organization. In the same way all intramural school work, clinic work, social service visits, were compared. (See chart and daily report.)

Responsibilities

1. All school nursing work for two grade schools, with a total of 911 pupils.
2. Some home visiting for a third grade school.
3. Four half days a week assisting in clinics.
4. All nursing and instructive home visiting in the ward, one section assigned to each staff nurse.

In the beginning, there were friendly sceptics who said that if bedside nursing were included in our program, all "educational" work would suffer, might even have to be dropped during the winter months when the acute illness curve rises. A few thought of the problem from the other angle. "Will mothers and their new babies have to wait all morning while their nurse inspects school children or helps in clinics?" The first objection was met by the offer made by the Visiting Nurse Association to stand ready to put in a specialized nurse for bedside work if ever the acute illness nursing seemed likely to swamp the educational. It was a problem to harmonize four types of work, handle four very different kinds of responsibilities. There were difficulties. The school work was managed by assigning two nurses to each school, one nurse in each team doing all intramural work one week, the other nurse the following week. At eight-thirty all of the staff except one nurse met at the office in Clay School. The other nurse went directly to Peabody School to do the routine inspections, exclusions and readmissions. As soon as the morning school work was finished, she went into her section to do bedside nursing and any other work which could be done. An absentee call requested by a teacher often coincided with a call for a nurse from a sixth ward family. Peabody School was located near the boundary line between the two districts served by the two nurses, so very little time was lost in getting into the homes. Usually she could be at work doing a dressing or caring for the mother and new baby by ten o'clock. Sometimes a patient needed care earlier than that;

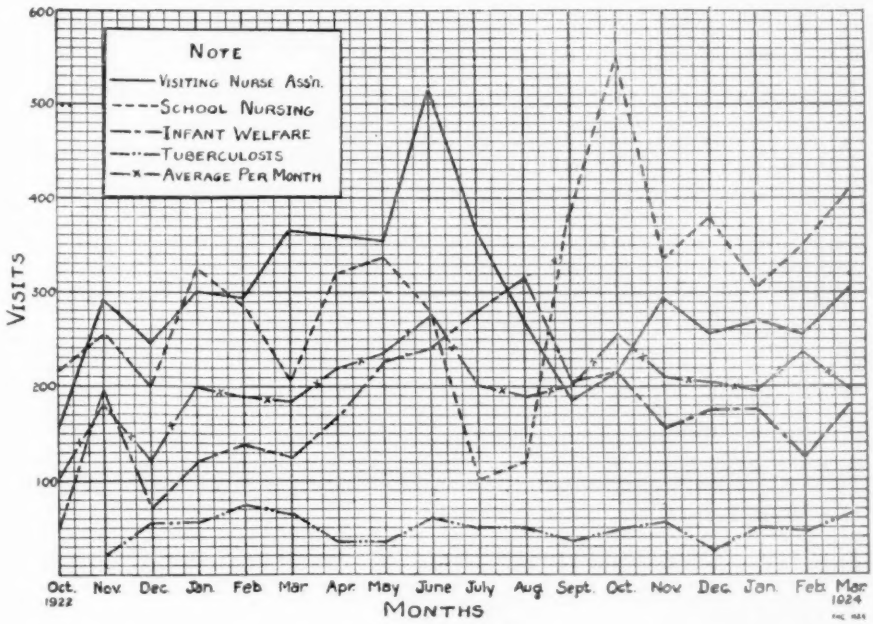
in such an emergency her teammate could be called upon to take her place in the school for a few days or a week, or the supervisor did the school inspections. The work was handled in the same way in the Clay School.

The two nurses who were not assigned to school duty for that week, spent from 8:30 to 9:00 or 9:30 in the office, according to the needs of their work, dictating records, conferring with teachers, supervisor, telephoning and planning the day's work. Absentee school children who were to have home visits were reported by the teachers, usually before 9:15 if the call were urgent. New visiting nursing calls were received and distributed. On the basis of old and new work, clinic duty, etc., the nurse planned her day's program and went into her section.

The Jackson School, with an enrollment of about 500, though in the sixth ward, had its own school nurse for all intramural work. All absentee calls and all follow-up visits after physical examinations within the generalized district were referred to the Sixth Ward Nursing Service. These calls were distributed by the clerk according to location, made by the nurses, and the reporting slips were returned to the Jackson School nurse that afternoon or the following morning. This system had its difficulties; the fact that half of the Sixth Ward staff had lunch with the Jackson teachers, and half with the Peabody, brought these two schools

"At any time of the year a specialized nursing service is more likely to be either overstaffed or understaffed than is a generalized nursing service."

—DR. C.-E. A. WINSLOW.



Dr. Winslow pointed out that the chart which hung in the office of the Sixth Ward Nursing Service was a good picture of one advantage of generalized nursing, that one type of work and then another can lead according to the season and the needs, but that the average number of visits per month is fairly constant.*

* NOTE: In June, 1923, intensive visiting to possible and prospective candidates for the Visiting Nurse Camp for Pre-tubercular children. Of forty children admitted to the camp from all parts of the city, eleven were from the generalized district.

more closely in touch with the nurses, and gave them a better chance to understand what we were attempting. It is only fair to say that the demonstration was not popular with many teachers. So much can be said for generalized nursing that in one's enthusiasm there is a tendency to forget to say the things which may honestly be said against it. To quote from the "log" of the demonstration, for May, 1923:

We are looking forward to the end of school and anticipating the comparative peace and quiet in our office, and the freedom from interruptions. . . . The fact that our office is in a school building, and that there is someone in the office at almost any hour of the day, makes it difficult to enforce our rule that teachers shall send pupils only during the morning inspection period. For the once that a child who is sent to us in the late morning, or in the afternoon proves to have fever or evidence of communicable disease, fifty children are sent with trifling ailments, excuses or messages. The generalized system has this disadvantage from the point of view of the teacher, that she does not know just which nurse is the one to consult about a certain child. Our whole district is divided into four sections, and in every school room there may be children from each section. Under the specialized system the school nurse can never thoroughly cover the ground, cannot do anything like such intensive work as we are doing. On the other hand there is this advantage, that if she does know something about a pupil which the teacher wants to know, the teacher can more easily find it out.

That the school work done in the generalized district was actually much more intensive is shown by the following table. The school population of the Clay and Peabody is the basis of comparison with a hypothetical average school of the size of these two together, anywhere else in the city, on the basis of the actual records—compiled weekly reports of 1923–1924—on file in the Hygiene Department of the Board of Education. *These figures are all proportional.*

School Nursing Work [1]

Generalized District		*Specialized District (Same Size)*	
151	inspections	100	inspections
118	exclusions	100	exclusions
76	excuses granted	100	excuses granted
153	absentee visits[2]	100	absentee visits
700	visits, follow up after physical examination[2]	100	visits, follow up after physical examination
400	children to dispensaries, clinics, etc.	100	children to dispensaries, clinics
	Defects Corrected and Treated at Clinics, Etc.		
48.4	children to dental clinic	10	children to dental clinic
27.2	children to eye clinic	10	children to eye clinic
72.1	children to surgical and medical, etc.	10	children to surgical and medical, etc.
5.	children to tuberculosis dispensary	1	child to tuberculosis dispensary

Another report from the "log" covering the first eighteen months of the Sixth Ward Nursing Service, shows the place of tuberculosis in the generalized scheme.

Our tuberculosis work so far as we can tell, compares favorably with that of the health department nurses. Our average number of patients is 47 and our visits per month are 47—one visit per month per patient. The average number of patients carried by the Health Department is 1,155;

NOTE 1.—Keep in mind that the district needed more intensive work than almost any other district of its size in the city. Had it been possible to compare figures for these two schools for previous years with those here quoted, we should have done so. Probably they would have run a little larger than for the city as a whole.

NOTE 2.—Probably a little too large, due to some Jackson School work which could not be estimated.

their average visits per month are 909. Our patients seem therefore to be under slightly closer supervision. Of the 115 tubercular cases assigned to the Sixth Ward nurses by the Health Department since our work began, five adults not previously reported as tubercular were found by our nurses and ten children with juvenile tuberculosis first "suspected" by them and brought to the attention of school physician or the Lymanhurst clinic. Many of the 115 were old cases carried for several years by the department. Some were registered as "suspect," some as "arrested" or "quiescent." In this connection some school nursing figures are interesting. Of the 98 children excluded by the Health Department this year from the schools as having juvenile tuberculosis eight were from the generalized district. This is the ratio of 5 per thousand to 1 per thousand exclusive of the sixth ward. But the incidence of tuberculosis in the sixth ward, including the fifteen cases reported first by the nurse, is in the ratio of 4 per thousand to 2.8 per thousand. It seems obvious that there are more children with juvenile tuberculosis in the city schools than are found and put under treatment where school nursing is specialized.

These figures and ones to follow are not quoted in any spirit of boastfulness. They are given as indications that under generalization, greater results may be expected for an equal amount of time spent in work. Another year and the figures might have been quite different. They prove nothing; they indicate a good deal.

In our infant welfare work, the generalized nurses have averaged 177 visits a month. The general average on the Infant Welfare Society staff is higher—199 visits per month per nurse. But the generalized nurses make one infant welfare visit for every 5 persons in the sixth ward and the specialized nurses one for every 15 persons in the city. During 1923 our "birth list" numbered 183. Of these 1923 babies, 63 came to clinic in 1923, 12 came early in 1924, a total of 75 babies registered with Pillsbury Clinic from a birth list of 183—that is 2 out of 5 from the generalized district compared with 1 out of 5 elsewhere. One Sixth Ward Nurse assists the I.W.S. nurse at every clinic—a total of 300 hours in 1923.

Concerning visiting nursing, a quotation from the same report shows:

In our V.N.A. work to date we have made 6,000 visits, an average of 300 visits a month. An analysis of the entire V.N.A. work including that done by the sixth ward district shows that the average is 203 V.N.A. calls a month. A comparison then of the work of the generalized district shows that we are making 3 visits for every 2 in the average district. One person in 8 in the city has a visit; in the generalized district, one person in 3.

In writing an article, it seems well to have a point of view. The point of view of this article, if it has one, is this: The Sixth Ward Nursing Service started life with several obvious handicaps:

1. No preliminary survey.
2. No adequate budget system; salary checks came from three different sources, a matter which sometimes seemed to take away from the feeling of unity in the staff. Requisitioning was difficult.
3. Awkward and inefficient record system.

There were, of course, other handicaps less obvious, but no demonstration starts under perfect conditions. In spite of these hindrances, the generalized district did some rather good work. The usual advantages found in generalized nursing: better contact in the home; time saved through the right of one nurse to handle four health problems instead of one only; saving of duplicate visits; saving in time in travel and in carfares; a family-health point of view on the part of the nurses making for greater keenness in detecting defects and symptoms of disease; all these were noted many times in the sixth ward, as they have been wherever generalized nursing has been undertaken.

Some Conclusions and Some Warnings

This paragraph is intended for any would-be starters of generalized districts. To the above mistakes which should serve as warnings, the writer would add more specific ones. It may safely be stated as a principle that difficulties lie in the path of the person who takes it for granted that the advantages of generalization are as clear to all people as to the enthusiast. Teachers and school principals, for instance, find it difficult to coöperate with health work which is really thorough. They are not rated for the health scores of their pupils but for success in getting them through examinations. Ideally teeth should always be filled on

Saturday; practically, some of them must be filled during school hours. Some see this; others are naturally blind to the importance of health work. The nurse must never lose an opportunity to coöperate with teacher or principal in all possible ways, so that her work will interfere as little as may be, with theirs; she must let them know what a generalized district does, give her work adequate publicity. Another suggestion: Do not try to combine in a generalized system people who are confirmed specialists. Probably there will be many who have greater faith in the convertibility of the non-believers in generalization, or greater powers for conversion than the writer.

The demonstration came to an end after two years. In the second year two surveys of the work were undertaken, one by Dr. C.-E. A. Winslow and the other by a committee of the Hennepin County Public Health Association. Each survey advocated continuing the work on a permanent basis. This, however, did not seem practicable, nor indeed possible at that time, due to local conditions. Perhaps Minneapolis is not yet ready for generalization. The experiment was worth while and tremendously interesting to all closely concerned with it.

EDITOR'S NOTE: The results of the Sixth Ward Nursing Service were studied in April, 1924, by Professors C.-E. A. Winslow and I. V. Hiscock, in connection with a general survey of the health program of Minneapolis, made at the request of the Council of Social Agencies and the Community Fund. Abstracts of their findings will follow in a later number.

GREAT AUNT HAYWOOD, OLA AND ZOLA

Down near the old haymarket district,—and to all who know Cleveland, the phrase "haymarket district" stands for one of the most congested areas of the city,—down here lives a colored family by the name of Haywood. It was a family of seven when we first made their acquaintance, the youngest members, Ola and Zola, being but a day old at that time.

When the twins were scarcely two months old Mrs. Haywood was taken to City Hospital with pulmonary tuberculosis, and within a few short weeks died there. What, then, of the little family? And what of babies, Ola and Zola?

Upstairs in the same house, if it deserved the name of house, lived Mr. Haywood's aunt, a maiden lady who had never been blessed with husband or children of her own. Thereafter, at every appointed day, there might be seen patiently waiting their turn at our well baby clinic, an old, gray haired colored lady—I use the word advisedly—and a heavy, drowsy colored man (he was working nights), each holding a small twin. Upstairs, where the little family now made their home, the place was neater than it had been below, and the children, somehow, cleaner.

We learned, not on our first visit, but after many, that this was not the first, but the third family great aunt Haywood had been called upon to raise. She was the oldest of a family of brothers and sisters orphaned at an early age, and had made a home for them. A family of nieces and nephews, of which Mr. Haywood was a member, had later required the same care. Now, at an age when she should be enjoying a well earned rest, she has taken in another family, two babies in arms and three older tots.

We like to call on Miss Haywood. She has those little wrinkles around the eyes which make one love her, little lines which radiate out, and which come from an appreciation of life and a keen sense of humor. She does not smile a great deal, but she gives an impression of pleasantness and sympathy. We wish she might know how highly we regard her, but we fear she is too busy to appreciate herself.

Esther Marion Alger, University Nursing District, Cleveland, Ohio.

A THREAT OF WAR AND AN OFFERING OF PEACE*

By Lewis H. Kilpatrick
Ex-Chairman, Montgomery County (Ky.) Chapter, The American Red Cross

KENTUCKY. Mid-autumn, with the lingering breath of summer warming the air. Rolling, rugged knobs, veiled by purple mists, shutting in a swampy bottomland, a quarter-mile from the dirt road. An unpainted, two-room shack, flush against a forest of mingled crimson and russet and gold. Sunday afternoon. Rustic stillness. Peace. But—Kentucky!

In the foreground, a little distance from the unpainted shack, was a Ford car, a Red Cross emblazoned on each door. A public health nurse, wearing the gray uniform of her service, stood nearby. She was a veteran and used to danger, but just now her cheeks were pale and she was rigidly, defensively erect.

Confronting her was a hillwoman, masculine in size, her eyes blazing wildly beneath her sunbonnet. She clutched a nine year old girl by the wrist, and her voice was angry and shrill:

"Ye haint a-goin' to tech my kid!" she cried, close to the nurse's face. "I'll kill ye, that's what I will. Ye haven't no business here. I'm a-goin' up yonder, git a shotgun and blow yer damn head off!"

There was no time for a soothing reply or an explanation. The woman turned and, dragging the child after her, started at a run toward the road from which the nurse had come.

The nurse stood still a moment, hesitating. This was not the first adventure of its kind she had had in the knob section of the county where she was the sole public health guardian. Three-fourths of the county lay in the Blue Grass, but where the good land ended most of her problems began.

For here was the scourge of Huntington's Chorea. A thousand men, women and children, populating the knobs about her, were its victims. Pure cases, most of them—and all descended from a single couple who had settled in this region a hundred years ago.

The frenzied mother was of that stock, the nurse knew. And she had no assurance that the mother would not carry out her threat. Each month there were "shootin's" among these hills, frequent murders from trivial causes, and the sheriff and his deputies were constantly raiding moonshine stills up the hollows.

The nurse's retreat by the road was cut off. The mother was nearly there, and by the time the Red Cross car could jolt over the trails to the last gate, she would have her shotgun. To abandon the car and escape into the woods might mean getting lost or finally being ambushed. The knob folk were clannish and their choreic tempers so much powder ready for the exploding spark.

But the nurse had no intention of retreating. Her hesitation lasted only a moment; then, with a fearless little smile, she went to the one door of the two-room shack. There lived the child's grandmother and the grandmother's second husband.

"Your daughter misunderstands my reason for being here," said the nurse to the grandmother, after the old woman admitted her. "She was out in the yard with the child, and when I got from the car and started toward them, she became suddenly angry. I'd hardly had a chance to utter a word."

The grandmother shrugged, adjusted her headrag and, with her apron, dusted a cane-bottom chair for the nurse.

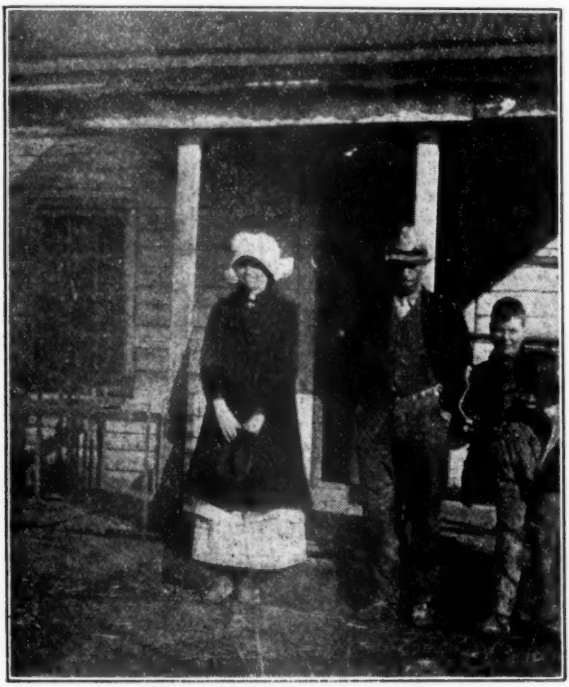
"Aw, ye mustn't mind Tilly," she exclaimed. "She never was reel

* *The second in the series "Our Adventurers."*

smart. Had this young'un by accident, and when she did marry she wed with an entire different man. They live up thar on the road and we keep the leetle gal, ye know."

"Yes," the nurse did know that much of the family situation.

"And the little girl has the itch," she added. "Her teacher notified me that he'd sent her home from school to be cured and for the protection of the other children. I've come to see her and tell you how to get her well."



Tilly, her Husband and Son

The grandmother was pleased. She seated herself beside her guest, there in the low-ceiled, bare-walled room, lighted by a single window. The shack's second room was between them and the outside door.

The nurse opened her bag and took from it a jar of ointment. This she gave to the old woman, with detailed instructions for its use and the general care of the child. The grandmother was attentive and eager to learn. She'd suffered from the "eetch" herself, off and on, all her life. She also was curious to learn if the nurse was married, where she was born, whether her parents were alive, and "how on airth she made that purty dress." Yes, the nurse said, she was kept very busy. Often worked on Sundays, as today. No, in response to another question, she wasn't afraid to go about through the hills alone. Nothing had happened to her—yet.

Her duty done, she rose to go. The old woman followed her from the room, through the kitchen-diningroom and to the door. The nurse glanced outside. There in the yard near the door, awaiting her, was the mother, Tilly.

Tilly's lank husband was with her. Behind them, shielded by their bodies, was the little girl, busily scratching her itch. But there was no sign of the shotgun.

The nurse smiled. The husband nodded and drawled, "Howdey!" Tilly looked sullenly at the ground and beat her broganed feet with a switch. The grandmother, standing in the doorway, watched and said nothing.

"Ye haint aimin' to take the leetle gal away, air ye, Miss?" asked the

husband abruptly, thus revealing the mother's fear.

"Certainly not," replied the nurse, and again explained the object of her visit.

"Thar now, Tilly," the husband burst out. "I told ye she didn't mean no harm. Listen, Tilly, at what she says."

But Tilly had disappeared. A moment before the nurse had seen her raw-boned figure dodge around the shack in the direction of the road. This time the child was left behind. . . .

Several minutes later the two women met again. The husband went ahead and opened the gates for the Red Cross car, and on the road, at the last gate, was the mother. She held a shoebox of ripe persimmons.

The nurse stopped her car for a final word. Tilly, her heavy features softened by a timid smile, handed her the persimmons—her peace offering. The nurse accepted them, smiled in return, and another day's work was done.

"The nurse" in this true Blue-Grass story is Florence Wallingford, who has been county nurse in Montgomery county, Kentucky, for three years. The nursing service is a joint service of the Red Cross and Health and Welfare League.

PUBLIC HEALTH NURSING IN CHINA

"Public health work will of course have to be done by the Chinese, but a few of us can start the ball rolling and initiate some methods," writes Miss Nina D. Gage, Dean of Hunan-Yale School of Nursing, and now at Teachers College, outlining briefly some of the activities already under way. Most Chinese nurses, she adds, seem to feel their responsibility for teaching what they know, so that if some teachers of public health go to China there will be huge results before many years have passed. Meanwhile Chinese nurses are intent upon learning what they can from observation and contacts abroad, and the Nurses Association is collecting funds to send at least one Chinese representative to the meeting of the International Council at Helsingfors.

All hospitals in China feel that it is part of their duty to initiate health education, for they must stand for something positive. But most of us are hampered by lack of funds and lack of staff. One nurse usually has the school and the hospital on her hands, and even if the hospital is small, when there is no one else who knows the first principles of cleanliness, let alone asepsis, supervision takes time, and one cannot go outside much.

The Council on Health Education of Shanghai is supported by the Y.M.C.A., the Y.W.C.A., the China Medical Missionary Association, and the National Medical Association (Chinese doctors only), and the Nurses Association of China. It disseminates health information, and publishes books, posters, and all sorts of literature on health subjects. The Council also publishes a quarterly magazine, *Health*, printed both in Chinese and English. Our Nurses Association contribution is arranging and conducting a course in home hygiene.

For the past two years, Maude Barton, a Massachusetts general nurse, with Simmons College and Henry Street public health training, has been organizing our work at the Hunan-Yale hospital. Last year she had two women and one man nurse under her, establishing contacts and following up the cases in the homes, helping our pediatrician with a well and a sick babies' clinic in connection with the Y.W.C.A., beginning prenatal work with some of these mothers, assisting with health examinations in the schools and doing the follow-up work, and visiting the various orphanages and poorhouses in the city under the Chinese city government and Board of Charities control. The hygiene of these places has been greatly improved through suggestions from Miss Barton and our public health doctor, Dr. Rex Atwater.

It seems to us that our best plan is to spend the men nurses' time on the boys' schools, following up health examinations and instructing in public health at the same time, for the younger generation is the most hopeful place to begin. With the women nurses we can meet not only the girls' schools but women, and can add instruction in prenatal health.

At the David Gregg Hospital in Canton and at Taiku hospital in Shansi, public health work has also been initiated. In Szech'uan, west China, separated from the rest of us by the rapids which make navigation difficult, so that they are three months inland from Hankow, they are just making an attempt to get into some of the homes, and to educate the officials to the need of health work. These officials are becoming interested in what the nurses can do, a new conception to them.

RURAL HEALTH VISITING IN ENGLAND

By Hester Viney

Cintra, Swanage, Dorset

Illustrations by W. Powell, Photographer, Swanage, Dorset

Typical old thatched cottage in Dorset, with the Purbeck hills in the background

With the growth of public health work in England, the attention of the local authorities has been drawn to the national importance of insuring good health to the rural population. Gradually there has spread all over England a network of Maternity and Child Welfare schemes involving a certain amount of supervision over the health of the community.

To visitors from other countries, the intense individuality of the counties of England constitutes a perplexing factor in any attempt to study a national movement as a whole. The application of an accepted principle in a movement social or ethical is in English country areas colored by the marked individuality of the county. Devon would approach the question from an entirely different angle from one of the great Ridings of Yorkshire; Cumberland again would present so different an aspect to the observer, that he might be tempted to look upon each county as a separate people, yet each is as profoundly English as is the nation of which it is a part.

When the 1918 Maternity and Child Welfare Act came into force some of the poorer counties could not afford an entirely separate health service, and undertook the work by appointing more nurses under the County Nursing Association, and giving them the health work to do with their other duties of midwifery, and sick nursing; the county paying for services rendered. Other counties have been able to organize a separate Health Visiting Service with which tuberculosis visiting and general child welfare, health work and school nursing is combined; other counties as in Dorset work partly by combining sick nursing and public health work under the County Nursing Association and partly by appointing whole time health visiting nurses, who only undertake county public

health work; the sick nursing falling to the lot of the district nurses. In the towns the work is still more subdivided; sometimes the school nursing coming under the Education Committee, and the health visiting under the Medical Officer of Health, the nursing of the sick under a voluntary association. In many rural districts there are no trained nurses appointed, and the handy woman from the village reigns supreme; therefore the only modern teaching given is from the health visiting nurse, whose duties do not include nursing the sick.

Health work in the rural districts was not warmly welcomed by the country people when it first began. Both nurse and her people were obsessed with the idea that country life was synonymous with perfect health. Realization that flagrantly to disobey the laws of healthy living brought the same punishment in the country as in the towns came later with the revelation of ill health and physical defect revealed by earlier school examinations in rural schools.

Country mothers of to-day are nearer modern life since they now have easier means of transport, and are therefore more receptive of new ideas. They have learned to welcome the district nurse, and her colleague the health visitor, as friends. They welcome too the school doctor and his examinations, and do not resent the verminous conditions inspections where they have a clear conscience over their own children.

Putting Remedial Measures Into Effect

The question of carrying out the doctor's advice is a difficult one. Remote country districts make the journey to a local hospital impossible: constant visits to the doctor make too big an inroad upon an inadequate wage. The counties supply free operations to children under a certain wage limit; maternity beds booked by the county in hospitals can be allotted to mothers, where home conditions forbid a confinement with safety, and for this a contribution is expected in most cases from the maternity benefit. Treatment centers for school children are held in the market towns regularly, and treatment can be given for such cases as ringworm by Assistant Medical Officers on application from the parents. The county authorities have schemes for treating and assisting tuberculosis patients, and people suffering from venereal diseases.

In Dorset the Red Cross Society of the county adapted a house in Swanage looking over the sea, as a War Memorial Hospital for Children; and to this any health visitor in the county can recommend a child under five years in need of treatment or special care by obtaining a doctor's certificate. Children from the schools in what is officially known as "the pre-tubercular stage" are sent here for preventive treatment, or to other convalescent homes for which the county pays the expenses. Surgical appliances are usually obtained by means of subscription letters from the Royal Surgical Aid Society. Children suspected of tubercular trouble may be sent to the county tuberculosis dispensaries in various parts of the county to be watched by the Medical Officers.

The rural schools are regularly inspected by the Medical Officers of the county, who examine the children, and report on the school buildings. The health nurse carries out regular inspections for cleanliness, visits in the homes, and reports children who are below the health standard to their own doctors or to the school medical officer for special examination. One dentist endeavors to cover all the school work but his devoted labor is of necessity inadequate. In Dorset the authorities have to deal with the diseases common to sea ports in such places as Bridport, Weymouth, and Poole which are in need of constant supervision. Chronic bronchitis is characteristic of the stone quarry workers of Purbeck and Portland; also of the clay workers of Creech. Tuberculosis is common in the county; bad housing and intermarriage in the villages help to keep up the spread of disease. It is now, how-

ever, vigorously attacked by the county authorities and prompt and efficient treatment is available for all.

Romantic but Unhygienic Housing Conditions

The housing is bad in most rural districts in England, and in some parts of Dorset. Stone houses are common in Purbeck and Portland; some of these stone cottages are of immense antiquity and are often very damp: overcrowding is common with its consequent evils of bad health among the young children. The water supply is another trouble; sometimes there is only one well for many cottages; sometimes one pump for the small hamlet: very often water is drawn from a stream which is not entirely free from suspicion after flowing near the farms, which "tastes in the tea." Fresh food is a difficulty for which the health nurse unless countrybred is unpre-

Inscription over doorway: Erected For the Prevention of Vice and Immorality By the Friends of Religion and Good Order

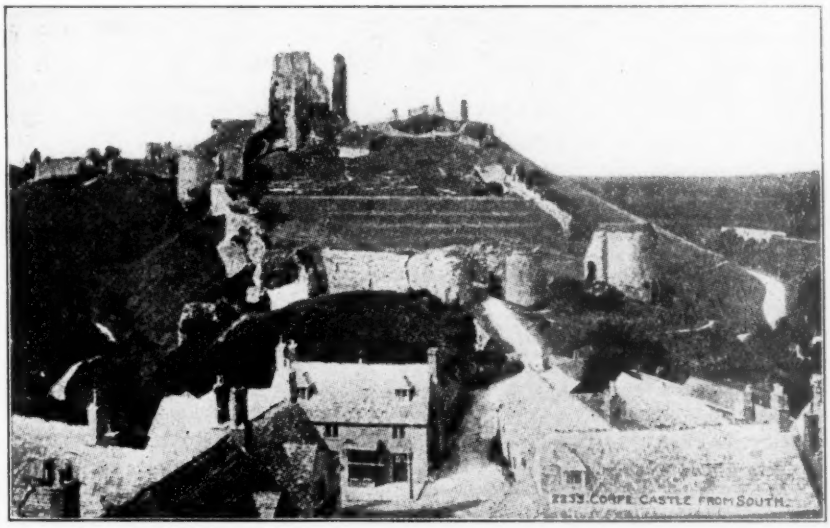
Relations used to feed the prisoners through the holes in the door

The Old Village Prison in Swanage

many have old niches for saints built into them stolen from the monasteries; and the writer has seen the remains of a holy water vessel in the wall of a cow barn. The moorland cottages are mainly built of mud walls with heavy beams and a thatched roof. They are comfortable enough, and have the wide chimney with the kettle swinging on a chain over the hearth-stone, and the old high backed "settle by thick vire side" of Barnes' poems where the family gather round on winter evenings. Where the family is a large one pared. Milk and eggs, butter, poultry and vegetables are sent to market; and it is not uncommon to find a family living on stale tinned food in a cottage so remote, that the nurse has to walk out about four miles across the moor to get there. Fresh air in such sweet abundance out of doors is often shut out from the cottage kitchen; the old windows are not made to open; the door when opened makes the fire smoke; and the housewife like the Breton woman in some cases lives indoors in semidarkness.

"Far Off Days and Battles Long Ago"

On the fascination of rural work in England and especially in the old Kingdom of Wessex the writer would dwell in loving detail. The close contact with nature, the infinite variety and beauty of the countryside, the charm and interesting characteristics of individual villagers, their ancient homes, and quaint dialect, together with their primitive simple lives, and their passionate love of their own countryside, the varied interests, and wide friendly acquaintance, the long rides in quiet country lanes, and the study of primitive instincts with the daily outdoor life and exercise fill the mind with great thoughts and contentment.



Corfe Castle

In Dorset the setting for the work of the health visitor is as an open book of English history: the past is ever with us, and the history of the old county is woven into the lives of those who live there.

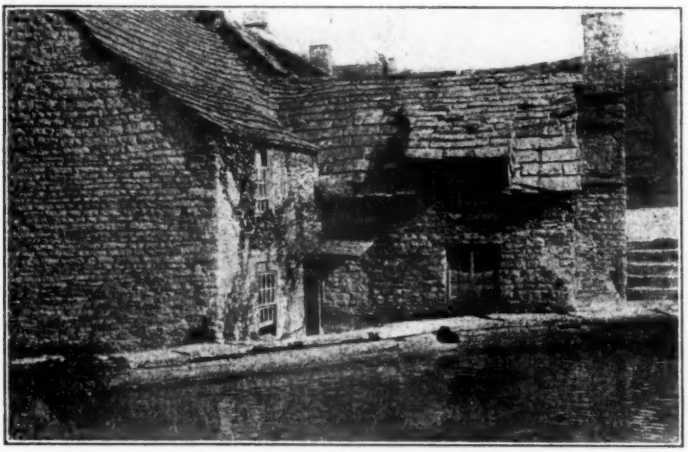
One day's round will carry the health visitor to Peveril Ledges where Alfred defeated the Danes in the first British naval victory, past the old battlefield where a Danish landing party was slain, and the stone quarries which Caesar found being worked when he landed; up the steep hill through Langton Matravers; the Old Langtone of the Doomsday Book, whose cottages bear the name of an ancient tax levied by William the Conqueror. The highest part of the road leads on through Kingston down to Corfe Castle, where the old Castle, once a Saxon stronghold, later a Norman fortress, stands in ruins after Cromwell's treacherous attack, and the gallant defense of it by Lady Bankes. Before the Castle gate the young Saxon King Edward was stabbed by the order of his stepmother. The horse dragging the body of the dead King fled towards Church Knowle where a red stain in the soil is still said to be from his blood. On through Church Knowle, which had a priest to serve its church when the Doomsday Book was compiled, and has probably had one ever since, past Barnston Farm, so-called from Bern the Saxon who held it in Edward the Confessor's reign, and which was taxed at 20/—in the Doomsday Book, up the steep road of Cocknowle to the top of the great chalk downs which stretch across Purbeck.

Here the modern health visitor can find shelter for her picnic lunch among the ancient barrows where the early Britons buried their dead with their hunting weapons and cook-

ing pots round them. Far away she sees on the right King John's old hunting lodge, and over the hill Studland where in 1205 he landed after a futile effort to attack France: across the great harbor lies Poole, once a household word amongst those who sailed the Spanish Main: on the near side of the water Arne is visible with its 13th century chapel and its altar cloth given in 1661 and still preserved. The way down hill leads past the clay pits, now working as an active industry employing hundreds of men, and which were used by the Romans during their occupation of Britain. At the foot of the hill lives an old Dorset woman, who still knows how to make magic draughts. Through Stowborough, separated from Wareham by a causeway, and once an early British settlement, over the old coaching bridge into Wareham, the principal market town on the area. Here are the remains of a priory founded in 709. The place is a fortress surrounded by earthen walls of great antiquity; the streets are straight since it was at one time a Roman camp; the old borough was constantly raided by the Danes. The place was a flourishing port until recent years, although it was caught up in all the wars in England, and it is still governed by a charter given by Queen Anne.

From Wareham the health visitor goes home by the little rural train running through the quiet valley; the setting sun lights up the cottage homes and farmhouses, shedding a glory over the hills. The country laborer walks home through the darkening lanes; he bears the same name that we can find written in the Doomsday survey of William the Conqueror for this countryside, and in the grave records of the Tudor Justices of the Peace; his home is the cottage in which his family have lived since his Elizabethan forbears built it; over the mantelpiece is the memorial given to the latest man of his race who gave his life for England; when he speaks he uses many words King Alfred the Great knew, and a large number of them he pronounces in the same way.

Such is the human material on which the English health visiting nurse with her modern outlook and teaching has to work, and such is the setting for her service. Well for her if she be countrybred; better if she can combine her enthusiasm for the modern conception of health and state service, with a humble reverence for the mighty past of this old Kingdom, and a passionate love of nature. Unless she bear a local name she will be a "furriner" at first, but gradually the countryfolk will take her to their warm hearts; and in their service she may find her fullest contentment, and serve her country well.



Sixteenth century stone cottage
Up to 1830 this was used as a "young ladies' school"

1123 Madison Avenue, Baltimore, Maryland

THE Instructive Visiting Nurse Association in Baltimore was made possible in the beginning by a few interested people who organized "to provide trained nurses to visit sick persons otherwise unable to secure skilled attendance, who could not or who should not be sent to a hospital, and to teach proper care of the sick."

A beginning was made in January, 1896, in one small section in South Baltimore, with one nurse. A second nurse was added the same year. In 1899 a superintendent was appointed, and although the salaries offered at this time were very small, other nurses with the same missionary spirit were added as the demand grew.

With the growth of the work there arose the need for definite headquarters, where the nurses could live, where information could be obtained and with a central office for the general conduct of the work.

* The ninth of the series depicting the homes and activities of voluntary, municipal and state public health nursing organizations.

In 1901, through the generosity of Mrs. Bertha Rayner Frank, the Rayner home, 1123 Madison Avenue, was placed at the disposal of the Association for a term of years, and in 1905 the house and contents were generously deeded to the Association.

With further growth the "Home" as it was originally presented was unable to keep pace with the activities of the Association and in 1910, through the generosity of the late Mrs. Thomas King Carey and some other friends, a three-story addition was built to the back of the house, providing ample accommodation for the work at that time.

Although the work of the Association since 1910 has developed far beyond the capacity of the "Home," it is still used as the Central Headquarters, and as far as possible the nurses whose homes are not in the city live there.

A home-like atmosphere has always been maintained and it is the consensus of opinion of the nurses who have lived there, that it has been really a "Home."

The Association has been the pioneer in public health nursing in Maryland. The first work amongst children was in 1898, when the trustees of the Thomas Wilson Sanatorium paid for two district nurses and placed upon the Association the task of visiting in the homes and sending babies to the sanatorium. With the organization of the Babies' Milk Fund Association of Baltimore this was no longer necessary.

The Baltimore Instructive Visiting Nurse Association was the *first* nursing organization to employ—in 1904—a special nurse for tuberculosis work. This work quickly developed until five nurses were employed, two supported by private individuals and three by the Tuberculosis Association. In 1910, when the City Health Department organized a Bureau of Nursing, this special work was transferred to this department, where it properly belongs.

In the same year, 1910, the Maryland Tuberculosis Association again placed a nurse under our charge to develop and demonstrate the need for the public health nurse in the county communities. The value of the nurse's work was so well demonstrated that the Association extended the work to other county communities, working in coöperation with the Maryland Tuberculosis Association.

With the advent of official organizations functioning in the counties the county work of the Instructive Visiting Nurse Association was no longer necessary. With the exception of supervision in one county, the work of the Association is now confined entirely to the city, which includes general nursing care to the sick of all races, creeds and color, in addition to the educational service rendered by instruction and advice in the home.

The present staff consists of the superintendent, two supervisors and twenty-six nurses.

PROBLEMS IN CONNECTION WITH THE ADMINISTRATION OF WELL BABY CLINICS

By Dorothy Deming
Director of District Nurse Association, Holyoke, Mass.

This is the third paper in the series on Well Baby Clinics. The first article, by Mary V. Pagaud, appeared in the January issue. The discussion in the February issue was contributed by Borden S. Veeder, M.D.

WITHOUT doubt, Miss Pagaud's article presents some of the most disputed problems in public health work, and it is to be hoped that others beside the writer will respond to the challenge of her questions.

What income limit, if any, should be adopted for patients attending a well baby clinic? The first problem—that of limiting baby clinic service to those unable to pay for the services of a physician, strikes an absolutely modern note. It is my opinion that the policy of asking those of moderate means to pay for service rendered is sound, whether it be for health service or other needs of daily life. Regardless of protecting the medical profession, is it not more constructive economically to separate those who can call a physician, leaving the space and time for free clinics to those unable to secure one? Is it fair to the general community to ask them to support a clinic for the self-supporting, is it quite honest, and is this the true purpose as understood by the donors, or by the taxed? Can we ever arrive at a knowledge of the cost of a free health service for a given community, if some of those residents in the community are grafting on the clinic people who would not normally fall within the scope of free service in any other phase of life? Furthermore, because a nurse is unable to impress a mother who can afford a physician's supervision for her child, with the value of this service, is this a reason why she should therefore offer a passport to a free clinic? Is the mother going to appreciate the service any more because it is free—will she use it more wisely? Experience proves the contrary. That classes, conferences, advice and opportunity to weigh the baby may be offered to all at the baby clinic goes without question. In this sense truly the baby station is free to all.

It would seem that if mothers of the " respectable middle class " are anxious to attend free clinics, some scheme of payment could, and should be worked out. It would seem that clinics free to all, regardless of income, are injurious, first, to the patient's self-respect; second, to the teaching of the public health nurse; third, to the physician; and last, but by no means least, to the community as a whole. It will be many a long day before real public health service equals the standards and staffs of our public school system. Some even question that it will ever come, since health is by its very nature so personal and private a thing.

How shall the financial status of patients be determined? To consider the second of Miss Pagaud's questions—If there is to be a service for a selected group, how is the group to be selected? The best answer seems to lie in Miss Pagaud's own plan. The income limit should be determined by the average cost of such medical supervision service in a community, and the average income of those appealing for it. This would vary greatly in different cities, and would probably have to be arbitrary in others, until figures are gathered and studied.

As to the method for obtaining the income data, it should naturally not be so expensive as to exceed the results.

If the patient's word is doubted, a check, such as that of telephoning the employer, would seem as simple and logical as any method. I see no reason why the bank clerk's family, and the day laborer's should not receive the same classification, if incomes correspond. Both may need education in healthy living to the same extent, in fact, the bank clerk's wife may need it more than the wife of the day laborer. Both should pay for their physician's service, and both should be asked at least, to pay for their home educational visits from the nurse. The task of the nurse will be greater in one family than in the other.

When shall prescriptions be given in a well baby clinic? It would seem to me that to issue from the clinic a prescription of any kind, for illness or the approach of illness, to a baby whose own physician has been promised the return of his case when illness occurs, would be a breach of integrity, to say nothing of professional etiquette. Rather let the clinic physician spend his extra two minutes in urging the reluctant mother to return to her own doctor. Occasionally it is possible to have clinic "standing orders," of which the family physician is informed, or if illness threatens, a call from the clinic doctor to the family physician may set things right between the two.

Shall physicians in charge of well baby clinics accept clinic patients as private patients when illness occurs? Unless there is a written, advertised agreement to the effect that clinic physicians may not be called as private physicians by clinic patients, why should we prevent a person from calling whomsoever she pleases to see her sick child? Do you hesitate, reader, to change your dentist, if you hear of a better, or one you prefer for some other reason? Surely not—and surely we cannot say, "so and so cannot call Dr. Jones, because Dr. Smith is her family doctor." If so and so wishes to call Dr. Jones, good—it is her free choice, and may Dr. Smith improve his methods, or his fees, or his office or his knowledge, and catch up to his rival's abilities.

A private doctor who refers cases to a clinic, and finds he is losing his practice, must either improve his methods or stop referring. The latter step would be an admission on his part that he could not keep up with the times.

Still supposing there is no rule regarding the physician conducting the clinic, and the patient knowingly calls the clinic physician as a private doctor, fails to pay him, and does not return to clinic—is it not her fault? The clinic is there—she is welcome to return. The case rests between the doctor and herself.

On the other hand, if there is a rule, I do not feel that the patient should necessarily be barred from the clinic, should she call the clinic doctor privately—certainly not for the first offense. Rather should the doctor, the more responsible of the two, refuse to respond to further calls, or responding knowingly, should he not be debarred from the clinic as infringing upon its rights and privileges?

It is indeed to be hoped that rules and promises to family physicians, as to what is to become of "their patients" if ill, will not be necessary in the near future. I often wonder what the fairly intelligent "case" thinks, as she is railroaded through from office to office in this game of social service!

All the questions in Miss Pagaud's paper bring these thoughts to a focus in my mind. Are we not assuming too much responsibility for our patients' thinking and acting? Are we not teach them to rely on us in matters which should be their personal decisions? Can we afford to follow up and follow up, teach and teach in the unresponsive home? Am I alone in a certain rebellion against the apparently endless patience with noncoöperation, displayed by some social service and health workers, or is my vision of usefulness and service too small to let me see the ultimate good?

INFANT WELFARE SERVICE STANDARDS IN DENVER

The standards of Infant Welfare service recently decided upon by the Visiting Nurse Association in Denver, Colorado, are given in this abstract from a letter received from Mrs. Kathryn Schulken, Superintendent of the Association.

Our whole pediatrician staff met with a committee of our Board, our supervisors and superintendent on November 14, 1924. Many points were discussed but as no definite decision could be reached it was decided to appoint a committee to work out a definite monetary standard, as that seemed to be what the pediatricians wanted. On the following day a committee appointed by Dr. Gengenbach, our chairman, composed of two members of the Board of Directors, two pediatricians, infant welfare supervisor, and myself, met and decided on the following standards:

Wife, husband and one child	$125.00
Wife, husband and two children	145.00
Wife, husband and three children	160.00
Wife, husband and four children	170.00
Wife, husband and five children	180.00

Increasing $10 for each additional child.

This was accepted as satisfactory by the entire committee.

The committee realizes that there will be many exceptions to the above standard. These exceptions are to be discussed by the nurse making the home visit with her supervisor and the doctor who is carrying the baby at the station. Their decision will be final on such cases.

One hundred and six of our infant welfare patients were above the standard quoted in the former paragraph. Probably one-third of these will be exceptional cases. We have had an average of 1,200 infant welfare babies each month during the year 1924.

The committee decided that mothers who have their babies cared for by private physicians may bring them to the stations to be weighed, without having the privilege of seeing our pediatricians, if they have the consent of the private physician who is giving health instruction to that particular baby.

It must be remembered that these standards as adopted in Denver will necessarily vary with the cost of living in different places and in different years.

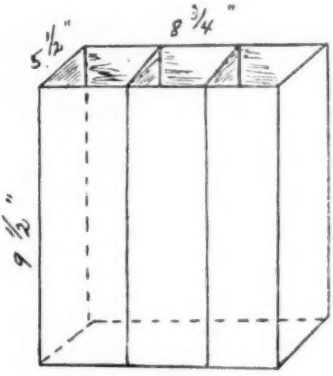
A PROTEST

The publication of the results of the physical examinations given the men selected by the draft came just after certain conditions among children with reference to physical unfitness had been made public. Various circumstances have combined to give this problem an extraordinary amount of publicity. One cannot go into a country store or look into the advertising section of a newspaper or a magazine without having his attention forcibly called to some aspect of the matter. The key word of the movement is nutrition and my protest is with reference to certain narrow uses of the term which are popularly made.

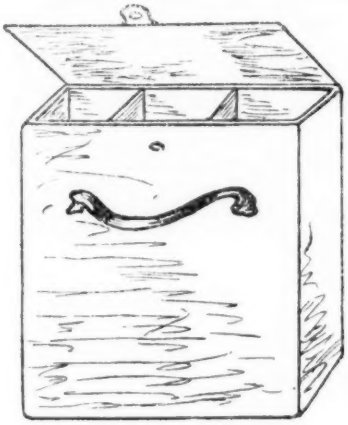
The most serious of these is the frequent tendency to use the word nutrition as a synonym for food or nutriment. No medical dictionary definitions justify this use, nor do the original Latin and French words from which the term nutrition comes. The term is concerned primarily with the *process* and not merely with the material involved. One might as well attempt to present the comforts of a home in terms of fuel as to undertake to discuss the process of nutrition only in terms of food. WM. R. P. EMERSON, M.D.

FURTHER NOTES ON COLLECTION AND DISTRIBUTION OF BREAST MILK

IN CONNECTION with the article in the January issue by Miss Dorothy Rood, "Collection and Distribution of Breast Milk," the Babies Milk Fund Association of Cincinnati, Ohio, has sent us sketches of the "special container" used for collecting breast milk, and the following comment on the statement, "there seems to be no provision for keeping the milk cool in the second transportation" made by Miss Rood:

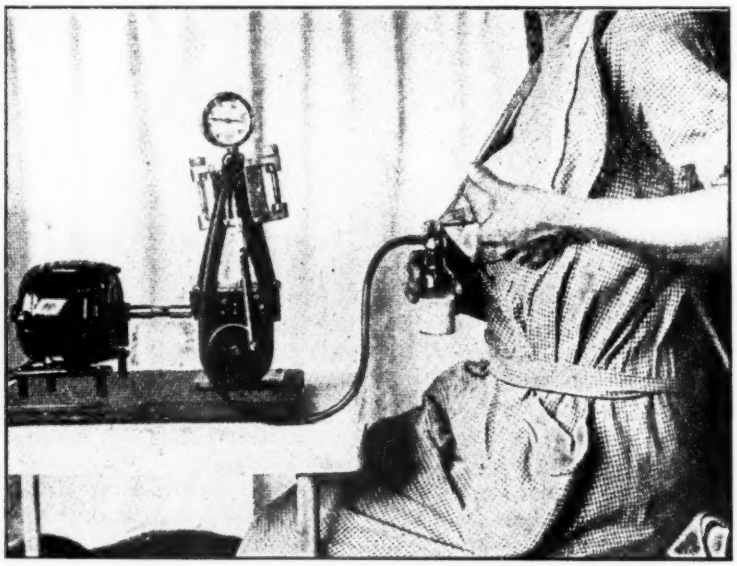


Tin Container



Case With Container

"We instruct those to whom we supply breast milk to always bring with them a metal container of some sort, usually a pail, in which the bottles are packed with ice. If a container is not supplied we fill an ordinary mason



Dr. Abt's Electric Breast Pump

jar with ice and wrap the bottles around this."

Although, as Miss Rood states, the milk is in most cases expressed by hand, an electric breast pump invented by Dr. Isaac A. Abt, of Chicago, is used successfully by the Chicago Lying-In Hospital. It has also for nearly two years been used in securing a milk supply from the wet nurses in the Sarah Morris Children's Hospital. The pump was described in an article printed in the *Journal of the American Medical Association,* from which the following abstracts are made.

Suction is made by an electrically driven, reciprocating pump with the aid of a vacuum chamber, combined with a special glass nipple shield. The degree of suction is registered by a gage which may be readily regulated to suit the convenience of the patient. There is a rubber tip attached to the bottom of the vacuum chamber, and a longitudinal slit in this tip permits the expulsion of the milk from the chamber into the receptacle. Vacuum is produced at every suction stroke of the pump, or about forty-five times a minute.

The glass chamber and nipple shield are attached to the pump by a rubber tube. The entire procedure may be carried out under strict asepsis, so that milk passes from the breast through the glass chamber into the desired receptacle without any possibility of contamination by the fingers or hands.

The breast may be emptied by the pump in about ten or twelve minutes. In some cases a period of five minutes was sufficient to empty each breast.

Advantages ascribed to the pump include:

Stimulates the secretion of milk
Relieves engorged breasts painlessly
Empties the breasts completely
Exerts an even pressure which can be adjusted, pump can be set so as to exert only amount of pressure absolutely necessary
Entails no breast infections
An aseptic means of milk expression
Beneficial in cases of inverted nipples
Can be used on fissured nipple
Most effective in obtaining milk from wet nurses.

The article by Miss Viney in this number gives a vivid picture of old England, picturesque but too often not up to the modern conception of hygiene and sanitation. Lest we take it too much for granted that we have nothing comparable in this country a recent editorial on Rural Sanitation in the *American Journal of Public Health* provides us with something to think about. We quote a few paragraphs:

In our rural districts, comprising nearly half of our total population and furnishing most of our food and clothing supplies, sanitary progress has as yet been remarkably slow, and such as has been made has been in spots too few and too far between. According to all the evidence at hand, not more than 3 per cent of the twelve million or so rural homes in the United States could now be given, after careful and competent inspection, a clean bill of health on the most salient features of sanitation. Such a situation is serious—serious from the standpoint of the individual, the local community, the state, and the nation—and deserving of the foremost attention of the local, state, and the federal governments. Sanitary improvements can be accomplished at a cost much less than the money loss which inevitably will result from their continued neglect. Thus, sanitation furnishes one of the least expensive and most profitable forms of insurance. Lack of progress in rural sanitation is not due to a lack of interest among our rural dwellers in their own welfare. It must be due, therefore, to a lack of information about the practicability and importance of sanitary measures. Extensive and intensive sanitary education, obviously, is essential to progress in rural sanitation.

The rural sanitation business is like any other business in that it will not run itself. Some one must be on the job whose particular and exclusive business is to look after it conscientiously, diligently, and constantly. Wherever the work has been looked after in a business-like way, the progress has been good. This is both encouraging and significant. . . .

Lasting progress in rural sanitation may be secured most economically and effectively through the development and maintenance of reasonably adequate local health service to carry out, under the direction of whole-time local (usually county) health officers, a well rounded, comprehensive program of health work including sanitation. Only about twelve per cent of our rural population as yet, however, have been provided with health service approaching adequacy.

THE INTERNATIONAL COUNCIL OF NURSES, HELSINGFORS, FINLAND, JULY 20–25

A Forest in Finland

PRELIMINARY PROGRAM FOR THE MEETING

JULY 20

Morning and Afternoon: Business and Council Meetings. Musical Church Service.

Evening: Opening Session. Delegates and Visitors to the Congress will be welcomed by members of the Board of Health of Finland. Addresses by Baroness Mannerheim; a member of Finnish House of Parliament; Miss Furuhjelm, representing the International Council of Women; and other prominent speakers.

JULY 21

Morning and Afternoon: General Sessions. Reports from different countries.

Evening: General Session. Introduction of new members. Greetings by representatives of the older National Associations and Pioneers of Nursing: Miss Huxley, Great Britain and Ireland; Dr. Anna Hamilton, France; Sister Agnes Karll, Germany; Miss Anna Maxwell, United States; Miss M. A. Snively, Canada, and others. Lantern slides of nursing in the different countries.

JULY 22

Morning: General Session on "Administration and Teaching in Schools of Nursing." Miss Goodrich will preside. Speakers from different countries.

Afternoon: Excursion to institutions and points of interest.

Evening: Miss Jentie Patterson will give a lecture demonstration of the Truby-King methods of infant care, with lantern slides.

JULY 23

Morning: General session on "Public Health Nursing." Presiding officer, Miss Jean Browne, President, Canadian Nurses Association. Mary S. Gardner, Elizabeth G. Fox and Evelyn Walker will speak. Addresses from representatives of many other countries.

Afternoon: General session on "Special Fields of Nursing." Presiding officer, Sister Agnes Karll, President German Nurses' Association. Speakers from different countries.

Evening: Open Meeting. Subject: "The Nurses' Place in the World's Health Movement." Speakers from different international organizations connected with nursing. Miss Goodrich will represent the International Council of Nurses.

JULY 24

Morning: General session on "Nursing Legislation." Presiding officer, Comtesse d'Ursel, from Belgium. Speakers from many lands.

Afternoon: Council Meeting.

Evening: General session on "Nursing Associations and Publications." Presiding officer, Miss Child, Honorary Vice-President of the South African Nurses Association. Miss Adda Eldredge, Miss Mary Roberts and representatives from a great many countries will speak.

JULY 25

Morning: Boat ride.

Afternoon: Social gathering and farewell. Presiding officer, Mrs. Tscherning, President of the Danish Nurses Association. Speeches by representatives nurses from each of the five continents.

Round Tables have been arranged in order to give an opportunity for the informal discussion of the most pressing problems in special fields of nursing. Arrangements for special groups to meet for luncheons and dinners will be made.

GENERAL INFORMATION

The S.S. "Caronia," which is the official steamer selected by the Transportation Committee, is scheduled to sail on July 8 from New York, arriving in Liverpool in time for the members to reach Helsingfors on July 20.

The Cunard Steamship Company is holding 200 reservations for those members desiring to take advantage of these and everyone is urged to make her reservation immediately through Thos. Cook & Son, 585 Fifth Avenue, New York, N. Y.

If more than 200 are booked for the S.S. "Caronia," Thos. Cook & Son will make reservations on any other steamship line the individual may desire.

The fare one way, from New York to Helsingfors, including all meals and sleeping accommodations, will be approximately $175, plus $5 United States government tax. An extra $10 will assure better accommodation on the "Caronia."

Those who are obliged to or wish to reach Helsingfors before July 20 are advised to make reservations on steamers sailing at an earlier date.

Thos. Cook & Son (above address) will answer all inquiries about accommodations on any steamship line.

The Swedish-American Line, with sailings from New York, July 2 and July 9, goes direct to Gothenburg, Sweden, and arranges for through transportation to Helsingfors in time for the meeting. The Norwegian-American Line and the Scandinavian-American Line also provide direct transportation to Scandinavia.

We also urge members going to Helsingfors to make *early* arrangements for their return passage.

In considering hotel accommodations in New York prior to sailing, nurses may be interested in the information submitted by a representative of the Hotels Earle and Holley, on Washington Square. The Hotel Holley was the mobilization station of the U. S. Army nurses prior to their sailing abroad during the war, and all the Knott hotels took care of different units while waiting for sailing orders. On the American plan, two persons to a room, the rates are $4 per person, and for single rooms, $5. On the European plan, the rate is $4 for a double room (two persons) and $3 for a single. More than seven-eighths of the rooms are with bath. If nurses arrive in groups, they will be met with buses and taken to the hotel at the rate of 25 cents per person, including hand baggage. The same arrangement can be made about taking them to the boat.

Cards for making hotel reservations in Helsingfors will be provided by the Transportation Committee, American Nurses Association, 370 Seventh Avenue, New York, and should be filled in and mailed early, not later than April 1, if possible, to:

Committee on Arrangements,
Kirurgiska Sjukhurst,
Helsingfors, Finland.

The Committee suggests that as far as possible arrangements be made for two people to share a room in Helsingfors.

Anticipating a desire on the part of most of those attending the Congress from the United States to visit other European countries than Finland, Messrs. Thos. Cook & Sons were asked to coöperate with the steamship company, and have prepared a special booklet suggesting a number of tours and containing all information necessary for travelers in Europe.

Tour 400 includes the Scandinavian capitals, London, Edinburgh, Paris, the Scottish Trossachs, Shakespeare's country, and the English Lake country, and costs $663. (All

costs cited in these tours include the cost of the passage to Helsingfors on the "Caronia," including war tax, and the five days of the Congress in Helsingfors.)

Tour 401 prolongs the stay in the northern countries and gives a trip through the most beautiful scenery of Sweden by way of the Gota Canal. It also includes London and Paris. The cost is $635.

Germany, Holland and Belgium, London and Paris, are included in Tour 402, at a cost of $637, or, if the trip is extended to include the Shakespeare country, Edinburgh, the Trossachs and Glasgow, the cost will be $701.

More extended travel in Germany is provided in Tour 403, including a trip by steamer up the Rhine. Switzerland, Paris and London are also included in this trip, which costs $762.

Stockholm, Christiania, the fjords and mountains of Norway, London and Paris, are scheduled for Tour 404 at a cost of $761.

Berlin, the Rhine, Switzerland, Italy, the Riviera, Paris and London make Tour 405 sound interesting. The cost is $905, with a possible extension to the Shakespeare country, Chester, Edinburgh, the Trossachs, and Glasgow bringing the total to $977.

Tour 406 includes Berlin, Dresden, Prague, Vienna, Munich, the Rhine, Switzerland, Holland, Belgium, Paris and London for $881, with the same extension as that arranged for Tour 404 bringing the cost up to $953.

Many of those attending the conference will undoubtedly wish to concentrate on the Scandinavian countries, lands of comparatively short distances and remarkable beauty.

Northern Europe has grown in popularity with the tourist since the World War, but it is doubtful if even yet the beauty of the northern countries is generally recognized. Finland, "land of a Thousand Lakes," with its deep pine and fir forests and leafy groves, its streams and rapids, all pervaded by the fairy-like light of the North, does not deserve to be known *only* through its capital, Helsingfors. A circular tour of the spots best worth visiting can be made in about ten days.

Stockholm, "the Venice of the North," with its palatial buildings, is only one feature of Sweden, the largest country in Scandinavia. Upsala, the ancient university city, Visby, romantic city of "Ruins and Roses," and the trip through the Gota Canal are other high lights in a visit to Sweden.

The fjords of Norway are too famous to need a detailed description but this Land of the Midnight Sun offers also snow-capped mountains, luxuriant verdure and superb color vistas.

Denmark is a land of pastoral beauty, the country of Andersen's Fairy Tales. Copenhagen, the capital, is the oldest and largest city of Scandinavia, and an important center of learning, art and literature. It is famous, too, for its modern hospitals.

NOME

The relief of Nome was accomplished by peaceful if heroic means, without the clash of battle and the marching men who have distinguished other great rescues of beleaguered cities. But it, too, had its heroes: Alaskan husky dogs who, once headed for Nome, reached it undaunted by snow and ice, wind and cold—drivers who laconically told their stories of unbelievable odds and more amazing records for speed as they rushed the diphtheria antitoxin to Nome—a lone doctor of the U. S. Public Health Service—and a public health nurse, Miss Emily Morgan, attached to the Columbia-Maynard hospital at Nome. According to a curt but pregnant news dispatch, "Miss Morgan is nursing all the stricken, even going into igloos and taking care of dying Eskimos."

Miss Morgan's story, when she has time to tell it, will no doubt be as thrilling as any which have come from Nome. She has been in Alaska since September, 1923, when she went to Unalaska, to the Jesse Lee Home, a Methodist mission school for Eskimo children. While she was in Unalaska Miss Morgan also did public health work in the community, going into the homes to care for confinements and to give other bedside care, and arranging mothers' conferences. She also went on several trips with government boats, to aid ship surgeons in emergency cases in nearby settlements. Before her Alaskan service she spent four years with the Wichita, Kansas, Public Health Nursing Association, and during the war she served in France as a Red Cross nurse.

REST HOMES FOR NURSES

Nurses' House at Babylon

WORLD-WIDE interest in providing rest homes for tired and convalescent nurses is evidenced in recent announcements from this country, from Tasmania, and from South Africa, of the opening of such houses.

A legacy from Miss Emily Howland Bourne to the Association for Improving the Condition of the Poor, in New York City, made possible the purchase of a house with ten acres of ground at Babylon, Long Island, which was opened in January, 1925. This will be known as the Nurses' House and will be maintained by the A.I.C.P. in coöperation with the New York County Chapter of the Red Cross, the Red Cross participating both in the management and the financial support. The Red Cross home at Bayshore, which is remembered gratefully by many nurses, has been closed, as the new home will take care of all needs. Mrs. August Belmont will continue as chairman of the Advisory Committee, made up of representatives from all types of nursing service, as well as from the two contributing organizations.

All nurses who have been ill or who are in need of rest will be welcomed to the Nurses' House, a roomy old mansion, near the Babylon station, but screened from traffic and noise by fine old trees. There are beautiful gardens, big porches, sunny living rooms, open fireplaces and a rarely beautiful view of the Bay. The house is near churches, library, post office, shops and movies. Thirty nurses can be accommodated now, and there are interesting possibilities for expansion. For advice or information about admission nurses may refer to Miss Alta Elizabeth Dines of the New York Association for Improving the Condition of the Poor, 105 East 22nd St., New York City, or Miss Florence Johnson, New York County Chapter of the American Red Cross, 598 Madison Ave.

South Africa

Near the little seaside village of Hermanus, South Africa, " The Homestead " has been opened as a holiday house for nurses, and, from the description of this charming spot, it should be an ideal rest home. The home itself is an old farmhouse with very thick walls; a long low stoep runs around two sides of it, and is the main feature of the house. Great purple mountains rise behind it, two minutes walk brings one to the sea which breaks on cavernous rocks and sandy beaches. An avenue of cypress trees leads to the house and there is a grove of " melkhout " trees, 300 years old at a conservative estimate. The one provision made by the donors of The Homestead was that these trees should never be destroyed or cut down.

The donors of the home, the first part of the Nurses War Memorial

Scheme to become an accomplished fact, are anxious that nurses from up-country and Rhodesia should be eligible to spend their vacations here, being firm believers in the healing power of the sea.

Declaring the home open, General Tanner said that the large community in South Africa had the greatest respect and honor for the services rendered by nurses and hoped that the establishment of this memorial would be a permanent token of the people's esteem.

Tasmania

Through the efforts of Returned Army Sisters, Tasmania also has recently opened a home for the rest, comfort and enjoyment of all nurses. Thus will be perpetuated the memory of three of their nursing comrades who died as the result of their war service. One of the rooms has been consecrated as the Sisters' Memorial to the Sisters. Other organizations contributing to the home are the Southern Tasmanian Red Cross Society, the Remembrance Club and the Returned Soldiers League.

The house is at Lindisfarne, on the slope of Natone Hill, from which the most beautiful view of river and mountain is obtained.

A memorial plaque hangs in the memorial room. It is an enlargement in blackwood, beautifully carved, of the Australian Army Nursing Service Badge. The names of the nurses to whom the home is dedicated are carved on the cross, which is a prominent feature of the badge. High tribute was paid by the speakers to nurses in peace and war and in particular to the three nurses who died as a result of their service, each of whom had a distinguished record.

MAY DAY

A defense day to which the veriest pacifist will willingly lend his approval is planned for the first of May. May Day will mean this year a voluntary mobilization in defense of the children of America, that they may be made impregnable to unnecessary disease and so safeguarded that they may start life at a high level of health.

Last year, under the sponsorship of the American Child Health Association, May Day was dedicated to child health, and the results amply warrant a continuance in 1925 and future years of the movement for positive health. This year it is hoped to set a standard of physical fitness and to see that the standard is maintained throughout youth. Much has already been accomplished, but in irregular areas, and results have been unequally distributed. This May Day will be one for general stock-taking by communities.

A chairman will be appointed in each state for the May Day celebration. This chairman will coöperate with designated chairmen within individual organizations, so that May Day plans may be effective not only for the one day but for a year of health activities. The newspaper and magazine press, the moving picture industry and the radio will help to emphasize the message of child health. Powerful organizations are standing back of the movement and important commercial bodies are coöperating.

No one in the country who has at heart the good of children can well be spared from joining in this celebration.

CHILD EDUCATION IN GREAT BRITAIN

A bill recently passed requires that all children in Great Britain shall attend school full time until they are twelve, and for at least 320 hours a year between the ages of fourteen and eighteen. It also provides for progressive increase of the age at which full-time schooling may cease and prohibits the employment of primary school children for more than one hour before and one hour after school daily.

Journal of Home Economics.

ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

Edited by ANNE A. STEVENS

THE RHODE ISLAND CENSUS OF PUBLIC HEALTH NURSING

Exclusive of Hospital Social Service, Dispensary and Industrial Nursing

ALTHOUGH the Census is a new method of collecting facts about public health nursing, the idea of gathering data on this subject is not new. In 1902, Ysabella G. Waters saw the opportunity of being of great service to organizations engaged in "visiting nursing," by giving information to them about each other. From that time until 1922 she sent out a questionnaire yearly to all those organizations employing public health nurses. At the end of this period she gave her files to the National Organization for Public Health Nursing. When we discussed with a well-known statistician the possibility of continuing her work by sending out questionnaires from our national office, he said it was impractical. On reminding him that Miss Waters had done it, he replied, "But Miss Waters was an angel!"

The purpose of the Census of Public Health Nursing is to present information about the administration and services of all organizations in the United States which carry on public health nursing activities exclusive, for the present, of nurses employed in hospital social service, dispensary and industrial nursing. The nurses included in the census count are graduate nurses employed for full-time service. According to the census plan, information about the organizations is obtained directly from each of them by means of a census form filled in by a representative of the organization. Therefore, the tabulations are based on statements that the organizations make about themselves. In this respect the census is different from a survey, where a trained observer visits and reports upon the various agencies. The organizations were asked to give information in the census returns as of January 1, 1924. Only nurses actually employed on that date are included in the count.

The chart and tables published with this text give the information which the staff of the National Organization for Public Health Nursing selected as necessary to describe public health nursing in the United States. The census returns from each state will be summarized as far as possible in tables similar to these for Rhode Island. Therefore this article on the census in Rhode Island may be considered as a sample of the information which will be available for every state, and summarized for the United States as soon as the census is complete. Every statement made concerning public health nursing in Rhode Island will then be comparable with similar statements about each of the other states.

In general, the method of gathering the census data in Rhode Island is the same as that used in other states. The Rhode Island State Organization for Public Health Nursing appointed Carolyn H. Boyce of the Providence City Health Department to act as the Rhode Island State Census Representative. We submitted a list of the Rhode Island organizations recorded in Miss Waters' file to the State Census Representative, who, with the help of other nurses in the State gave us the information necessary to prepare a complete list of all the organizations employing public health nurses on January 1.

The census forms were sent out to these organizations by the State Census Representative in the middle of April. Complete returns were received by October 18.

Distribution of Nurses as to Territory, Population and Organizations

On January 1, 1924, there were in Rhode Island 131 full-time graduate nurses giving public health nursing service, exclusive of those employed in hospital social service, dispensary, and industrial nursing. If this number were evenly distributed as to territory there would be one nurse to each 8.1 square miles. If the 131 nurses were evenly distributed according to population there would be one nurse to every 4,614 persons in the State. Outside the city of Providence there would be one nurse to 6,435 persons. (See Table 4.) One can compare these figures with those of Indiana, given in the November 1924 issue of THE PUBLIC HEALTH NURSE, page 597, where the ratio is one nurse to 12,010 persons for the entire State and 17,099 outside the city of Indianapolis. The percentage of population living in areas which had a nursing service available was 95.9 in Rhode Island and 66.6 in Indiana. It is known that public health nursing services are more readily organized in urban areas. Therefore, these large differences may perhaps be accounted for by the fact that Rhode Island's population is 97.5 per cent urban, while Indiana's is only 50.6 per cent urban. One should remember that these figures are based on the 1920 United States Census of Population. If population figures were available for January 1, 1924, these ratios would be less favorable.

Nursing services were available to the entire population of Kent and Bristol counties. (See Chart I and Table 4.) In Providence, Newport, and Washington counties with a total population of 543,015, only 24,799 lived in areas without a nursing service. In these three counties, services were available to all places but the following towns: Foster, Lincoln, Scituate, Jamestown, New Shoreham, Portsmouth,* Charlestown, Exeter, Richmond, and parts of Hopkinton and South Kingstown. Nursing service of some type was available to all those places in the State with 10,000 or more population. Central Falls and Cumberland, although not listed on Table 2 as being the headquarters of a service, were being served by an organization located in Pawtucket.

The 131 nurses were distributed among 26 organizations. (See Table 1. Four were employed by the United States Veterans Bureau. None were employed by the State. The remaining 127 were employed in 25 local organizations. Of the 127 nurses employed in local organizations, 21 were under official administration, and the remaining 106 under nonofficial administration. (See also Table 2, Line 4.) Eighty-five of the 106 were employed in public health nursing associations or similar organizations. Seventy, or 55 per cent, were in Providence; 19 in the City Health Department and 51 in the District Nursing Association. The only other organization employing 10 or more nurses was the Pawtucket and Central Falls Chapter of the American Red Cross, which had 13. These three largest organizations had 65 per cent of the 127 employed in local organizations. (See Table 3, Column 5.)

Number, Type and Size of Organizations

On January 1, 1924, there were 26 organizations in Rhode Island giving public health nursing services. Only 4 of these were under official administration. These were the United States Veterans Bureau, 2 local boards of health and one local board of education. (See Table 1.) Rhode Island appears to be unique in that it had no nurses in its State Board of Health who gave either a direct service to patients or an advisory or supervisory service to other public health nurses. The 22 other organizations were local ones under nonofficial administration. Of these 22, 15 were public health nursing associations or similar organizations; 3, American Red Cross chap-

* Since January 1, 1924, the Portsmouth Public Health Nursing Association has been organized.

ters or branches; 1, Metropolitan Life Insurance Company service; and 3, other nonofficial agencies. Thus, the largest group of organizations is that of public health nursing associations.

Among the local organizations there were 13 employing only one nurse, 9 employing 2 to 9 nurses, and 3 employing 10 or more nurses. (See Table 3.) As one might expect, the majority of the one nurse organizations, or 9 of them, were located in places of 10,000 or less. Those organizations having 2 to 9 nurses were scattered in the population Groups IV, V and VI, the groups which include cities of 50,000 population or less. The 3 largest organizations were located in the two largest cities, Providence and Pawtucket. These 3 organizations together employed nearly twice the number of nurses employed in the remainder of the State.

Character of Nursing Program and Kind of Nursing Service

In reading Tables 5 and 6 one should keep in mind the point, brought out in the second paragraph of this article, that the tables are based on statements which the organizations have made about themselves. We asked for data as to whether certain services were included *in the nursing programs* of the organizations. In some cases it appears that organizations reported as to whether they had *ever given* a particular service in their last fiscal years. According to Table 5, one organization alone reported that it gave curative care only. This is a District Nursing Association. Of the 4 local organizations giving instructive care 2 were boards of health; one a board of education; and one a public health nursing association. Nineteen of the 25 local organizations gave a service which included both curative and instructive nursing. Twelve services of this type were given by public health nursing associations. The other 7 are scattered among the American Red Cross, Metropolitan Life Insurance Company services and all others.

In relation to the kind of nursing service given (See Table 6) it should be noted that either or both curative and instructive care can be given for many types of service listed in Column 1. All but 4, or 21 local organizations, gave care to acute and chronic medical and surgical cases. Maternity service of some type was given by 21 organizations, and 10 had a delivery service. Twenty-one organizations had a tuberculosis service. It is interesting to see how the number of organizations drops to 10 for diphtheria, and 9 for scarlet fever and erysipelas. It can be seen that school nursing in Rhode Island is the responsibility of organizations under nonofficial administration, since only 3 out of the 15 which gave that service are officially administered.

Sources of Income

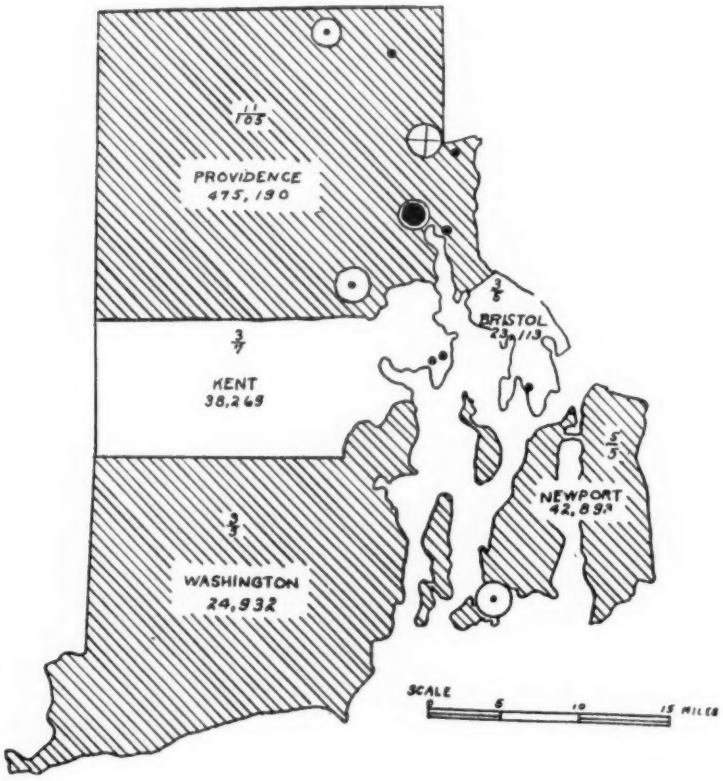
After seeing that all but 3 of the 25 local organizations are under nonofficial administration, one might expect to find that these 22 organizations were entirely supported by private funds. However, this is not the case. (See Table 7.) Two public health nursing associations received State funds in their last fiscal years preceding January 1, 1924. Sixteen of the 22 nonofficial organizations received township funds, while 3 more received city or village funds. Although public funds are not used for employing public health nurses under official administration, public funds have been given to a great majority of the nonofficial agencies in amounts varying from $100 to $6,000. Thirteen of the nonofficial organizations received Christmas Seal funds; 14, membership dues, contributions. A larger number of organizations received support from patients and the Metropolitan Life Insurance Company than from any other one source.

Salaries

Because of the few organizations it is not possible to make any summary of the salary facts given in Table 8. The kind of summary which may be made for larger states was illustrated in the November 1924 issue of THE PUBLIC HEALTH NURSE, page 595.

RHODE ISLAND

CHART I. NUMBER OF ORGANIZATIONS EMPLOYING PUBLIC HEALTH NURSES AND NUMBER OF FULL-TIME GRADUATE NURSES EMPLOYED IN EACH COUNTY, JANUARY 1, 1924



EXPLANATION OF MARKING OF MAP

I. Population of cities

- 100,000 and over
- 50,000 to 100,000
- 25,000 to 50,000
- 10,000 to 25,000

II. Distribution of services

- Nursing service available for entire county
- Nursing service available for part of county

III. Number of organizations and full-time nurses

Indicated by fractions:
Numerator denotes ORGANIZATIONS
Denominator denotes NURSES

IV. Population of county -- United States Census, 1920

Indicated by numbers in each county

TABLE I. GENERAL SUMMARY

A. GENERAL FACTS ABOUT THE STATE

Area in square miles, 1,067
Number of counties, 5

I. POPULATION DATA, UNITED STATES CENSUS, 1920

Population	604,397
Population per square mile	566.4
Per cent of United States population	0.6
Number of families (estimated)	134,310
Number of negroes	10,036
Per cent of population in rural areas (*i.e.*, unincorporated territory and incorporated places of less than 2,500 inhabitants)	2.5
Per cent of population who are foreign-born white	28.7

II. VITAL STATISTICS, 1923

Number of live births	14,442
Number of deaths	8,622
General birth rate per 1,000 population	23.0
General death rate per 1,000 population	13.8
Deaths of infants under one year of age per 1,000 births	94.3

B. PUBLIC HEALTH NURSING IN THE STATE

I. DISTRIBUTION OF ORGANIZATIONS

	Number of organizations	Number of full-time nurses
The state	26	131
Classified according to type of administration:		
Federal organizations	1	4
State organizations	..	..
Local organizations	25	127
Official administration:		
Boards of health	2	20
Boards of education	1	1
Other official boards	..	..
Joint administration, two or more official boards	..	..
Non-official administration:		
Public health nursing associations or similar organizations	15	85
American Red Cross chapters and branches	3	15
Tuberculosis associations	..	..
Metropolitan Life Insurance Company services	1	1
Other non-official organizations	3	5
Joint administration, two or more non-official agencies	..	..
Classified according to size of staff:		
One nurse organizations	13	13
Organizations with two or more nurses:		
With two to nine nurses	10	35
With ten or more nurses	3	83

II. RATIOS OF DISTRIBUTION

Per cent of population living in areas in which a local nursing service is available:	
In the entire state	95.9
Outside the city of over 100,000 population (Providence)	93.2
Ratio of nurses to territory (entire state)	1 nurse to 8.1 square miles
Ratio of nurses to population:	
Entire state	1 nurse to 4,614 persons
Outside Providence	1 nurse to 6,435 persons

III. COUNTY SUMMARY

Number of counties in which a nursing service is available for entire area	2
Number of counties in which a nursing service is available for part of area	3
Number of counties without a nursing service	0

TABLE 2. ORGANIZATIONS EMPLOYING FULL-TIME GRADUATE NURSES, AND NUMBER OF FULL-TIME GRADUATE NURSES EMPLOYED, CLASSIFIED ACCORDING TO TYPE OF ADMINISTRATION, AND BY POPULATION GROUP AND CITY

Note: Figure before dash indicates NUMBER OF ORGANIZATIONS and figure after dash, NUMBER OF NURSES, employed in them.

Population group and city	Population 1920 census	Total number	Official administration				Non-official administration						Joint official and non-official administration
			Board of health	Board of education	Other official boards	Joint administration two or more official boards	Public health nursing association or similar organizations	American Red Cross	Tuberculosis association	Metropolitan Life Insurance Company services	All others	Joint administration two or more non-official organizations	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
The state	604,397	26–131	2–20	1–1	1–4	....	15–85	3–15	....	1–1	3–5	....	....
Federal organizations		1–4	....	....	1–4*	....	....	....	....	....	....	....	....
State organizations		....	....	....	....	....	....	....	....	....	....	....	....
Local organizations		25–127	2–20	1–1	....	....	15–85	3–15	....	1–1	3–5	....	....
I. 500,000 and over													
II. 100,000 to 500,000													
Providence	237,595	2–70	1–19**	....	....	....	1–51	....	....	....	....	....	....
III. 50,000 to 100,000													
Pawtucket	64,248	1–13	....	....	....	....	....	1–13	....	....	....	....	....
IV. 25,000 to 50,000													
Woonsocket	43,496	2–8	....	1–1	....	....	1–7	....	....	....	....	....	....
Newport	30,255	2–2	1–1	....	....	....	....	....	....	1–1	....	....	....
Cranston	29,407	1–4	....	....	....	....	1–4	....	....	....	....	....	....
V. 10,000 to 25,000													
Central Falls	24,174	....	....	....	....	....	....	....	....	....	....	....	....
East Providence	21,793	1–3	....	....	....	....	1–3	....	....	....	....	....	....
West Warwick	15,461	1–5	....	....	....	....	1–5	....	....	....	....	....	....
Warwick	13,481	1–1	....	....	....	....	1–1	....	....	....	....	....	....
Bristol	11,375	1–2	....	....	....	....	1–2	....	....	....	....	....	....
Cumberland	10,077	....	....	....	....	....	....	....	....	....	....	....	....
VI. Rest of state, including all cities and towns of less than 10,000 population and rural areas	103,035	13–19	....	....	....	....	8–12	2–2	....	....	3–5	....	....

* U. S. Veterans Bureau.
** City Health Department includes: (1) Division of Child Hygiene (2) Division of Communicable Diseases.

TABLE 3. ORGANIZATIONS EMPLOYING FULL-TIME GRADUATE NURSES AND NUMBER OF FULL-TIME GRADUATE NURSES EMPLOYED, CLASSIFIED ACCORDING TO SIZE OF STAFF, AND BY POPULATION GROUP, AND CITY.

Note: Figure before dash indicates NUMBER OF ORGANIZATIONS and figure after dash, NUMBER OF NURSES, employed in them.

Population group and city (1)	Total number (2)	One nurse organizations (3)	Organizations with 2 to 9 nurses (4)	Organizations with 10 or more nurses (5)
The state	26–131	13-13	10-35	3–83
Federal organizations	1–4	....	1–4	....
State organizations	....	....	....	....
Local organizations	25–127	13-13	9–31	3–83
I. 500,000 and over				
II. 100,000 to 500,000				
Providence	2–70	....	....	2–70
III. 50,000 to 100,000				
Pawtucket	1–13	....	....	1–13
IV. 25,000 to 50,000				
Woonsocket	2–8	1–1	1–7	....
Newport	2–2	2–2	....	....
Cranston	1–4	....	1–4	....
V. 10,000 to 25,000				
Central Falls	....	....	....	....
East Providence	1–3	....	1–3	....
West Warwick	1–5	....	1–5	....
Warwick	1–1	1–1	....	....
Bristol	1–2	....	1–2	....
Cumberland	....	....	....	....
VI. Rest of state, including all cities and towns of less than 10,000 population and rural areas	13–19	9–9	4–10	....

TABLE 4. DISTRIBUTION OF PUBLIC HEALTH NURSES IN RELATION TO POPULATION

Area (1)	Number of counties (2)	Number of nurses (3)	Population, 1920 census: Entire area (4)	Population, 1920 census: Area in which nursing service is available (5)	Population, 1920 census: Area in which nursing service is not available (6)	Percentage of population living in area in which nursing service is available (7)	Number of persons to one public health nurse: Entire area (8)	Number of persons to one public health nurse: Area in which nursing service is available (9)
The state	5	131*	604,397	579,598	24,799	95.9	4,614	4,424
City of Providence		70	237,595	237,595	00,000	100.0	3,394	3,394
Outside of Providence		57	366,802	342,003	24,799	93.2	6,435	6,000
Counties in which nursing service is available for the entire area	2	12	61,382	61,382	00,000	100.0	5,115	5,115
Counties in which nursing service is available for part of the area	3	115	543,015	518,216	24,799	95.4	4,722	4,506
Counties without nursing service	0	0	00,000	00,000	00,000	00.0	0,000	0,000

*4 nurses in the U. S. Veterans Bureau.

TABLE 5. CHARACTER OF NURSING PROGRAM OF ORGANIZATIONS EMPLOYING PUBLIC HEALTH NURSES, CLASSIFIED BY TYPE OF ADMINISTRATION, AND BY POPULATION GROUP AND CITY

Note: C—indicates CURATIVE service only; I—indicates INSTRUCTIVE or PREVENTIVE service only; C: I—indicates COMBINED CURATIVE AND INSTRUCTIVE services given.

Population group and city	Total number of organizations	Summary of character of nursing program			Official administration				Non-official administration						
		Curative	Instructive	Curative and instructive combined	Board of health	Board of education	Other official boards	Joint administration two or more official boards	Public health nursing association or similar organizations	American Red Cross	Tuberculosis association	Metropolitan Life Insurance Company services	All others	Joint administration two or more non-official organizations	Joint official and non-official administration
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
The state	26*	1	5	19	2	1	1	....	15	3	....	1	3	....	....
Federal organizations	1	....	1	....											
State organizations	....	....	....	....											
Local organizations	25*	1	4	19											
I. 500,000 and over															
II. 100,000 to 500,000															
Providence	2	....	1	1	1-I	....	....	....	1-C:I	....	....	....	....	....	....
III. 50,000 to 100,000															
Pawtucket	1	....	....	1	....	....	....	....	....	1-C:I	....	....	....	....	....
IV. 25,000 to 50,000															
Woonsocket	2	....	1	1	....	1-I	....	....	1-C:I	....	....	....	....	....	....
Newport	2	....	1	1	1-I	....	....	....	....	....	....	1-C:I	....	....	....
Cranston	1	1	....	....	....	....	....	....	1-C	....	....	....	....	....	....
V. 10,000 to 25,000															
Central Falls	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
East Providence	1	....	....	1	....	....	....	....	1-C:I	....	....	....	....	....	....
West Warwick	1	....	....	1	....	....	....	....	1-C:I	....	....	....	....	....	....
Warwick	1	....	....	1	....	....	....	....	1-C:I	....	....	....	....	....	....
Bristol	1	....	....	1	....	....	....	....	1-C:I	....	....	....	....	....	....
Cumberland	....	....	....	....	....	....	....	....	....	....	....	....	....	....	....
VI. Rest of state including all cities and towns of less than 10,000 population and rural areas	13*	....	1	11	....	....	....	....	1-I 6-C:I*	2-C:I	....	....	3-C:I	....	....

* No information from one organization in Group VI.

TABLE 6.—KIND OF NURSING SERVICE GIVEN BY ORGANIZATIONS EMPLOYING PUBLIC HEALTH NURSES, CLASSIFIED BY TYPE OF ADMINISTRATION

Kind of nursing service	Total number of organizations in the state giving specified services	Official administration				Non-official administration						Joint official and non-official administration
		Board of health	Board of education	Other official boards	Joint administration two or more official boards	Public health nursing association or similar organizations	American Red Cross	Tuberculosis association	Metropolitan Life Insurance Company services	All others	Joint administration two or more non-official organizations	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
Total number of organization in the state	26	2	1	1	....	15	3	....	1	3	....	....
Acute medical or surgical	21	....	....	1	....	14	3	....	1	3	....	....
Chronic medical or surgical	21	....	....	1	....	13	3	....	1	3	....	....
Maternity service:												
Prenatal	20	....	....	....	....	13	3	....	1	3	....	....
Delivery	10	....	....	....	....	7	1	....	....	2	....	....
Post-natal	21	1	....	....	....	13	3	....	1	3	....	....
Communicable diseases:												
Tuberculosis	21	....	....	1	....	13	3	....	1	3	....	....
Diphtheria	10	1	....	....	....	3	3	....	1	2	....	....
Scarlet fever	9	1	....	....	....	3	2	....	1	2	....	....
Erysipelas	9	1	....	....	....	3	2	....	1	2	....	....
Syphilis	14	....	....	....	....	8	3	....	1	2	....	....
Gonorrhea	16	....	....	....	....	9	3	....	1	3	....	....
Other	3	1	....	....	....	2	....	....	....	....	....	....
Poliomyelitis after-care	15	1	....	....	....	8	2	....	1	3	....	....
Mental conditions or disorders	15	....	....	1	....	10	1	....	1	2	....	....
Preschool children (Birth through 5 years)	20	....	....	....	....	13*	3	....	1	3	....	....
School children (6 years through high school)	14	1	....	....	....	7	2	....	1	3	....	....
School nursing	15	2	1	....	....	8	2	....	....	2	....	....
Insufficient information regarding details of nursing program	....	....	....	....	....	....	....	....	....	....	....	....
No information at all regarding nursing program	1	....	....	....	....	1	....	....	....	....	....	....

* In one organization service is given to children from birth to two years only.

TABLE 7. SOURCE OF INCOME OF ORGANIZATIONS EMPLOYING PUBLIC HEALTH NURSES, CLASSIFIED ACCORDING TO TYPE OF ADMINISTRATION

Source of funds	Total number of organizations in the state receiving funds from specified sources	Official administration				Non-official administration						Joint official and non-official administration
		Board of health	Board of education	Other official boards	Joint administration two or more official boards	Public health nursing association or similar organizations	American Red Cross	Tuberculosis association	Metropolitan Life Insurance Company services	All others	Joint administration two or more non-official organizations	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
Total number of organizations in the state	26	2	1	1	....	15	3	....	1	3	....	....
Public funds:												
Federal	1	....	....	1	....	....	....	....	....	....	....	....
State	2	....	....	....	....	2	....	....	....	....	....	....
County	....	....	....	....	....	....	....	....	....	....	....	....
Township	16	....	....	....	....	11	2	....	....	3	....	....
City, town, or village	6	2	1	....	....	3	....	....	....	....	....	....
American Red Cross	4	....	....	....	....	2	2	....	....	....	....	....
Christmas Seal	13	....	....	....	....	11	....	....	....	2	....	....
Community Chest	....	....	....	....	....	....	....	....	....	....	....	....
Dues and contributions:												
Membership dues	14	....	....	....	....	11	1	....	....	2	....	....
Contributions	14	....	....	....	....	10	2	....	....	2	....	....
Bequests and gifts for endowment	1	....	....	....	....	1	....	....	....	....	....	....
Interest on endowments	4	....	....	....	....	4	....	....	....	....	....	....
Fees paid by—												
Patients	17	....	....	....	....	13	2	....	....	2	....	....
Metropolitan Life Insurance Company	18	....	....	....	....	12	2	....	1	3	....	....
Industries	2	....	....	....	....	....	1	....	....	1	....	....
Other sources	11	....	....	....	....	11	....	....	....	....	....	....
No information	....	....	....	....	....	....	....	....	....	....	....	....

TABLE 8. SALARIES OF STAFF NURSES EXCLUSIVE OF EXECUTIVES AND SUPERVISORS
Salaries are tabulated to nearest $5.00

Monthly salary	One nurse organizations	Organizations with two or more nurses							
		With full-time nurse supervision				Without full-time nurse supervision			
		2 to 9 nurses		10 or more nurses		2 to 9 nurses		10 or more nurses	
		Minimum	Maximum	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
(1)	(2)	(3)	(4)	)	(6)	(7)	(8)	(9)	(10)
Total number of organizations in the state	13	9	9	1	1	1	1	2	2
Total number of organizations replying as to salary	11	8	8	1	1	1	1	2	2
$175	....	....	....	....	....	....	....	....	....
150	1	....	2	....	....	....	....	....	....
145	....	....	....	....	....	....	....	....	....
140	....	....	1	....	....	....	....	....	....
135	....	....	1	....	....	....	....	....	....
130	....	....	1	....	....	....	....	....	....
125	3	2	2	....	1	....	....	....	1
120	....	....	....	....	....	....	....	....	1
115	2	....	1	....	....	....	1	....	....
110	3	1	....	....	....	....	....	....	....
105	....	1	....	....	....	....	....	....	....
100	....	2	....	1	....	1	....	2	....
95	....	....	....	....	....	....	....	....	....
90	1	2	....	....	....	....	....	....	....
85	....	....	....	....	..	....	....	....	....
80	....	....	....	....	....	....	....	....	....
75	....	....	....	....	....	....	....	....	....
70	....	....	....	....	....	....	....	....	....
65	1	....	....	....	....	....	....	....	....
Median salary	$115	$102.50	$132.50	....	....	....	....	$100	$122.50
Modal salary	....	....	....	....	....	....	....	$100	....
Range	$65–150	$90–125	$115–150	....	....	....	....	....	$120–125

Conclusion

Rhode Island is smaller in territory than any of the other states, but it has a larger population per square mile than any of the states. With a dense population one can see that fewer public health nurses are needed than where population is scattered, and it has been agreed that when this is true a nurse can take care of more patients. These facts should be kept in mind when comparing the ratio of public health nurses to population in Rhode Island with that of other states where the ratios may be more favorable, but the population more scattered.

M. W. B.

POLICIES AND PROBLEMS OF PUBLIC HEALTH NURSING SERVICES

We regret it is necessary to delay until next month the publication of the questions raised by the circulation of the Visiting Nurse Study Report now being considered by the Visiting Nurse Study Advisory Committee.

VALUE AND FUNCTIONS OF A NURSING COMMITTEE

The question of *"The Value and Functions of a Nursing Committee"* is one we believe to be of interest to all nursing organizations. To begin the discussion we offer statements from a Bureau of Public Health Nursing of a State Department of Health, a County Health Association, a Red Cross Service and a Visiting Nurse Association. We hope to continue this in a later number. Contributions to the discussion gratefully received.

The Nursing Committee is probably the most important committee in our County Public Health Association. The chairman of this Committee is elected at the annual meeting, is a member of the executive committee of the association, and calls together the members of the committee bi-monthly to talk over nursing problems in the county. In each county the number of nursing committee members varies, as each community group has one nursing committee member, who may or may not appoint one or more assistants.

The functions of the Nursing Committee as we interpret it are, first, the employment of the nurse; second, to hold regular meetings for taking up the various phases of nursing work with her; third, to assist the nurse in getting acquainted in the community, and to interpret her work to that community; fourth, to act as eyes and ears for the nurse, helping her find cases needing her assistance, reporting all communicable and other cases needing care to her; fifth, to receive calls in the absence of the nurse; sixth, to keep available a list of nurses and of persons capable of doing practical nursing who might be available for emergency cases; seventh, to give the nurse assistance in school inspections, finding people to assist with weighing, measuring, records, etc.; eighth, to give the nurse assistance at clinics, finding people to assist with clinic routine.

Bureau of Public Health Nursing, Oregon State Board of Health

In Dutchess County, New York, the township is the local unit in community organization for health work, and the Township Public Health Committee the local group which works closely with the county district nurse. Each of the four county nurses covers four townships as her territory and thus has four committees. We have been finding these committees very successful and feel that they represent the best type of nursing committees for rural work.

The committee usually has twelve members: a chairman, a secretary, and two members on each of five working sub-committees—call, clinic, publicity, supply, school. The committee meets at least bi-monthly on a set day of the month and follows a routine order of business:

Reading of minutes.
Reports of sub-committees.
Report of nurse, covering
(1) activities in local township,
special problems,
plans.
(2) activities in other towns of district.
(3) county nursing news.
(4) state and national nursing news, health work, etc.

The call members are chosen from two largest centers in the township and their functions are to receive and relay to the nurse the calls for her services. They also render any other assistance which is not covered by the other committees.

The clinic members assist with the preparations for and the conduct of the clinics.

The publicity members are responsible for not only the regular newspaper publicity but also arrange for the nurse to speak before local groups, for poster displays, and for health educational literature distribution.

The supply members see to the equipment of a loan chest or closet.

The school committee assists with the clerical work in connection with the medical examination of the school children, preparing the lists of defects for the use of the nurse in home follow-up work. We have in mind other possibilities for our school committees, such as the promotion of hot lunches, active interest in improving sanitary conditions in schools and school-grounds, etc.

The regular meetings of the committee, with their formal order of business, the fact that each member has a well-defined function and responsibility, and the presentation of a carefully prepared nurse's report which links up local work with the larger fields—all this is tending to make these nursing committees stronger and more alive as the months go by. Their place in the rural health program is of unmeasured value. Committee work is well worth a large share of the nurse's time in the beginning, for, after a few months, she finds her committees becoming such sources of encouragement and strength to her as to more than compensate for all they cost her in time and effort.

Dutchess County Public Health Association, New York

When a new service is to be inaugurated there should be some definite preparation of the field before the arrival of the nurse. This preparation should take the form of publicity and the accumulation of certain information such as area to be covered, population and its distribution, nationalities, type of roads, topography of country, names and location of doctors, dentists, hospitals, school authorities, helping teachers and others with whom she will coöperate, the number and location of schools and the school population of each, and the type of industries and location. A map of the territory will be helpful to her in learning her district.

This information will very definitely help the nurse in making a start and save her much valuable time. It will also have the additional advantage of keeping the committee interest alive.

In consultation with the nurse the program should be planned and policies worked out for conduct of the service. The relationship between the committee and nurse should be one of partnership, for in planning the program the technical experience of the nurse, combined with the business sense and varying points of view of the members of her committee will be the best means of working out a well balanced practical plan.

Another important function is budget planning, which again is best worked out in consultation with the nurse. The budget is one of the best means of safeguarding the permanency of the service.

In our Red Cross services we find that one valuable function performed by our committees, together with the nurse, is that of educating the public authorities in a better understanding of the value of public health nursing and in an appreciation of standards, against the time when the work is taken over and supported from public funds. An example of this kind will serve as an illustration of what is a repeated Red Cross experience.

The committee and nurses in this community worked in such close coöpera-

tion with the municipal authorities that at the end of two years the city was helping with a good sized appropriation. Three years after the service was started the work was taken over completely and two members of the nursing committee, one of whom was the chairman, were placed on the Welfare Commission under which the service is now operating. Another member of this commission, the chairman, is the husband of a former Red Cross nursing committee chairman. The municipal authorities in making these appointments fully recognized and appreciated the importance of standards. Needless to say the nurses who were both qualified public health nurses were taken over with the service.

In the absence of a state Bureau of Public Health Nursing in the state this Commission became affiliated with National Red Cross in order to safeguard standards and to enable the nurses to have field advisory service from the Red Cross field nurses.

The Red Cross nursing service always encourages our committees to send reports of the work to the school and municipal authorities, particularly if these bodies are contributing towards the support of the work. We also encourage our committees to invite them to appoint representatives on the nursing committee whenever public funds are used.

Other functions of our committees are those of deciding matters of salary, vacation, sick leave, leave of absence, providing suitable office, equipment, supplies, telephone, and means of transportation.

We also feel it to be the duty of a committee to be mindful of the personal welfare of the nurse, by safeguarding her against overwork and discouragement. There are many duties to be performed which many times committees could assume but in an unthinking moment shift the responsibility to her shoulders. She should be helped in finding congenial friends and agreeable recreation; and of great importance, a suitable and homelike place in which to live. If more thought were given to the personal happiness and welfare of the nurses there would be fewer resignations.

Myrtie E. Taylor, Field Representative, Nursing Service, American Red Cross

Our Nursing Committee consists of five members of our Board of Directors, with the President and Superintendent as members ex officio. The Chairman is appointed by the President following the annual meeting. The Committee meets once a month at the Visiting Nurse office on the Wednesday preceding the regular monthly Board meeting, and to it are brought various problems concerning the nursing work. The recommendations of this Committee are later presented to the Board for adoption or discussion.

As we have no regularly functioning Executive Committee, problems are also brought to this Committee that might not otherwise come under its jurisdiction—as auto expenditures, purchasing of equipment, etc.

The functions of our Nursing Committee are:

1. Securing as well as dismissing the Superintendent. All other applications and resignations go to the Superintendent, who presents them to the Committee with her recommendations.

2. Acting as counsellor and guide to the Superintendent. Special problems of sick leave, vacations, salaries, overwork, leaves of absence, etc., are discussed with this Committee. All new projects for extending the work are gone over with this Committee before being presented to the Board as a whole. Any complaints as well as appreciations for services rendered are taken up with the Committee, as are requests for special types of nursing service, extra night work, or requests which we feel we are not justified in meeting.

3. This Committee also acts as an Advisory Council on affiliated work with other organizations as the Associated Charities, Erie General Dispensary, etc.

Some of the things accomplished by our Nursing Committee this last year are:

1. Making it obligatory for the nurses employed by the Visiting Nurse Association to be registered and to meet the minimum requirements of the N.O.P.H.N. One year from date of notice was given to the staff to fulfill this requirement.

2. Raising the salary schedule to meet the average salaries given throughout the country.

3. Making it possible to enlarge the staff by addition of two nurses and one clerical helper.

4. Interesting the Board in the Report of the Committee to Study Visiting Nursing, resulting in our adoption of the methods of record keeping recommended therein.

The value of an active Nursing Committee is inestimable, not only for the assistance it can give to the Superintendent in interpreting nursing problems to the Board of Directors and to the community at large, but in the satisfaction resulting to an executive of an Association from the knowledge that she has back of her a small group of women especially interested in the nursing work and to whom she can go when in doubt.

A list of available practical nurses and substitute nurses for emergency work is kept in our own office, and securing lay helpers for our Child Health Stations is the work of our Child Welfare Committee.

Visiting Nurse Association, Erie, Pa.

This Committee, like all other sub-committees of the Board of Directors, should meet regularly (a week before regular meetings of the Board is suggested) and make reports and recommendations to the Board or Community Committee.

All questions relating to the nurses are first considered by this Committee before being acted upon by the Board. Such questions are: program of the nursing work; questions of the nurses' individual work and conduct; policies regarding salaries, vacations, sick leave, leave of absence for any other reasons, hours on duty, promotions; educational program for the nursing staff as a whole or for individual members, such as staff lectures, conferences, attendance at conventions or meetings, trips to observe other work; uniforms; quarters; equipment; supplies—in short, everything pertaining to the nurses as individuals or as a group. This Committee also is valuable because its members are thoroughly familair with every detail of the nurses' work and can interpret it to the entire Board or Community Committee, the members of which are then capable of helping to secure understanding coöperation from the community. This makes possible the carrying out of the fundamental principle on which all public health nursing is based, namely, the close coöperation of the lay and the professional worker, insuring permanence by placing definite responsibility on a continuing committee of the community rather than on any individual who may be temporary.

As the nursing work grows, such a committee may function best by appointing sub-committees for special phases of the work, but such delegation of responsibility is considered unwise until really necessary.

Statement prepared by the N.O.P.H.N. in response to request as to detail functions of Nursing Committee.

RESPONSIBILITIES OF THE NURSE IN SOME POINTS OF BABY WELFARE WORK

In the February number the following questions were discussed by the Rochester Public Health Nursing Association, the Boston Community Health Association, the

Pittsburgh Public Health Nursing Association, and the University Public Health Nursing District, Cleveland, Ohio. Here is further discussion from Baltimore, St. Louis and Detroit.

Question 1. Is it permissible for a nurse in the field to raise, lower or otherwise change the formula of a baby under her supervision?

I should be unwilling to have a nurse in the field raise or lower or otherwise change the formula of a baby under her supervision without securing the consent of the physician.—*J. H. M. Knox, Jr., M.D., Bureau of Child Hygiene, Baltimore, Md.*

We feel definitely that the formula should be prescribed by the physician. Since, however, so much is left to the mother's judgment, we do not limit strictly the nurse's power of decision.

As an emergency measure, until the mother can return to Conference with the baby (often the day following the nurse's visit) we do allow the following changes to be made:

1. A formula, recently prescribed, and the baby is having frequent stools—we advise reducing the amount of sugar.
2. In summer, or at any time with severe diarrhea—to omit the milk and to give plain boiled water.
3. A baby who is constipated—increase the amount of Karo (if the formula includes that).—*Municipal Visiting Nurses, St. Louis.*

In the two welfare clinics which this Association administers, we do not feel that the nurse has the privilege of changing the formulae without authorization of the clinic doctor.—*Visiting Nurse Association, Detroit, Mich.*

Question 2. How much responsibility can the nurse assume for a baby whose mother does not bring it to the conference and does not have a family physician?

I do not believe that a nurse can carry on medical work. The responsibility for the well-being of a young baby is a medical one and the nurse should secure medical advice either from a conference physician or from a practitioner for a baby whose mother is without this help.—*J. H. M. Knox, Jr., M.D., Baltimore, Md.*

A pamphlet is left, and general instruction given for care of baby—breast feeding at regular intervals is urged. No formula is prescribed.—*Municipal Visiting Nurses, St. Louis.*

In the instance of the indifferent mother who refuses to bring her baby to clinic or to call a family physician, we feel that the nurse visiting the family could tell the clinic doctor the conditions and bring back to the family his recommendation under ordinary conditions. But if the seriousness of the case necessitates the doctor seeing the baby, the nurse would be expected to take the baby to the clinic herself.—*Visiting Nurse Association, Detroit, Mich.*

Question 3. How long should a baby be carried under these circumstances?

The baby should be carried by the nurse only until medical help can be obtained.—*J. H. M. Knox, M.D., Baltimore, Md.*

A baby who is referred to us by some social or health agency is visited in the home—and unless under the care of a private physician, is invited to attend the Child Welfare Conference. If at the end of two months the child has not attended Conference, another home visit is made, and if still uncoöperative the case is closed. Since with a limited personnel it has not been possible to devote more time to these seemingly uncoöperative cases, exceptions to this general rule are made whenever the nurse in the district feels that the mother for some particular reason is unable to attend the Conference, but is interested in the instruction the nurse can give her.—*Municipal Visiting Nurses, St. Louis, Mo.*

If anything can be gained by the continuous visits of the nurse to the family we do not dismiss the baby because the mother refused to bring him to clinic.—*Visiting Nurse Association, Detroit, Mich.*

RED CROSS PUBLIC HEALTH NURSING

EDITED BY ELIZABETH G. FOX

BOYS' AND GIRLS' CAMPS AND THE PURSUIT OF HEALTH

EVERY year in almost every part of the United States, when summer comes, a large army, so to speak, of boys and girls leave their homes for a pleasant and healthful season of camp life in the mountains, valleys, and forest, by the lake or by the sea. With this youthful army goes a smaller one of instructors, councillors, nurses and doctors, for in many camps there is a doctor, and in most it is considered highly desirable to have a resident, graduate nurse. Where there is no full-time resident nurse, the nurse in charge is often the local public health nurse, especially in camps planned by the Y.M.C.A., Boy Scouts and Camp Fire Girls.

It is customary to make certain that the boys and girls have a healthful environment in so far as water, food, shelter and the like are concerned. But with every facility at hand for constructive health work, such as healthful environment, trained instructors and "health specialists," we often fail to see and take advantage of the basic fact that: youth is primarily interested in the growth and development of its physical being; youth abhors physical abnormality; to youth physical perfection is the normal state. We are prone to call the attainment of the best possible health by the wrong names, and to present it in the wrong way. If we called the attainment of health in its most perfect form, beauty, strength, joy in life, efficiency and greater ability to give service, and made all this a project, we would see the boys and girls strive and strain and sacrifice for this great possession.

There are many different types of boys' and girls' camps—pay camps, part pay and free camps. In all of them there is a veritable gold mine of opportunity for the teaching of personal and community hygiene, and for arousing the enthusiasm of the boys and girls for both.

Braxton County, West Virginia, has made a start in this direction. Last spring a camp was held for the Health Squad of the Sutton High School, an organization which has as its chief object—"Training for Physical Fitness." In the Health Squad Camp this year we hope to make everything else subservient to this one idea. Some special constructive health work has also been done in the annual 4-H Camps of Braxton County.

To explain very briefly what 4-H Camps are: 4-H Clubs are now in existence in forty-four states, under the direction of the State University Extension Divisions. They are organized for the rural boys and girls between the ages of ten and eighteen years. The clubs meet monthly, and all work is carried on by the project method. Each "4-H'er" must carry on a continuous project such as sewing or raising a pig or a lamb. The object of the club members is to develop the "4-H's"—Head, Hand, Heart and Health, and so to become symmetrical men and women. The club discovers and develops leaders who will later be real factors in their own communities. West Virginia has been outstanding in 4-H Club work.

Annually, each county in West Virginia in which these clubs are organized holds a 4-H Camp in which the campers are divided into seven or eight Indian tribes each with its chief, and its own "Council Fire." The camp is run as a democracy, with all the work done by the campers themselves, though there are paid instructors and regular classes in basketry, nature

study, and similar subjects. The highest ideals of the 4-H's are held constantly before the boys and girls. There are tests to prove the development of the Heart, Head, Hand and Health, and as the children reach certain stages of efficiency in all the "H's," certain insignia are awarded, the very highest being the "all star" pin. One of the highest ambitions of every "4-H" boy and girl is to possess this pin.

In one of the recent annual 4-H Camps of Braxton County, West Virginia, the following health program was carried on. This, it should be understood, is but the briefest account of the work.

The camp started in a good environment and with a program which included consideration of the camp's location, shelter, food, "setting-up" exercises and athletic games. A camp "Health Unit" was formed consisting of a "health officer," "sanitary engineer" and "nurse," elected from the campers. This unit held daily conferences with the county public health nurse (who was resident in the camp). The members of the unit made sanitary inspections and gave in regular reports at the morning assembly. They helped to outline the daily health program, and saw that it was carried out. They were very quick to find defects in the original plans and to suggest improvements.

The doctor and public health nurse, as part of this program, gave demonstrations and talks on the building of sanitary toilets, treatment of drinking water to make it "safe," personal hygiene, and similar subjects. A health talk was given at each morning assembly, and an effort made to present the subject in an interesting way. The other special points in the daily health program were:

1. Health inspection of each camper, and reports on same A.M. and P.M.
2. Tooth brush drill before breakfast.
3. Hand washing and inspection before each meal.
4. All drinking water treated by "Camp Health Officer" to make sure of its safety.
5. Sanitary dish washing by campers.
6. Health play given on "stunt night."
7. "Points" awarded for performance of any personal or camp "health chores."

This entire program was made the project of the Health Unit of the camp. At the end of camp, the "health officer" sent in a report of the health work to the State Health Commissioner, which received very favorable comment.

The county public health nurse made plans with the camp director and doctor, with the approval of the County Agent and the Home Demonstration Agent, under whose direction the camp was conducted. They gave the fullest coöperation and not only helped materially to put the health program across, but they inspired all the boys and girls with enthusiasm for the health project.

The above is only a start in the right direction. We are all health teachers, and should be able to excite the interest of our boy and girl campers in the following questions:

What is a reasonable health ideal?
Why should we want it?
How can we get it?

Having stimulated interest, we should help them to go after the answers with all their ardent, youthful enthusiasm.

HELEN E. BOND,
Red Cross Public Health Nurse,
Braxton County, W. Va.

CHANGES IN THE ORGANIZATION OF THE AMERICAN RED CROSS

In the interests of a more closely knit organization and of economy, and in order to bring the Red Cross chapters and the national officers more nearly in touch, the American Red Cross has undergone somewhat of a reorganization. The divisions, as such, were abolished February 15th. Chapters and State and Local Committees on Red Cross Nursing Service in what were formerly the New England, Washington and Southern Divisions will hereafter be directed and supervised from National Headquarters. Chapters in the former Central and Southwestern Divisions will be supervised from a National Branch Office in St. Louis, and those in the former Pacific Division from a National Branch Office in San Francisco.

The difference between a division office and a national branch office is this: The division office was an organization unit imposed between the national office and the chapter. The branch office will not be an intermediate unit but simply an extension of the national office itself.

While this reorganization has many advantages it has one distressing feature. The elimination of the divisions and the setting up of three offices in the place of seven necessitates a rearrangement in staff and the discontinuance of several division directorships.

The American Red Cross thus suffers the severe loss of some of its nursing leaders who have given valiant service over a long period. Miss Jane Van De Vrede, Miss Olive Chapman and Miss Virginia Gibbes will all enter other fields of endeavor. Miss Van De Vrede and Miss Chapman will both take long needed rests before considering future avenues of nursing service. Miss Gibbes is to become the Director of public health nursing for the municipality of Knoxville, Tennessee.

While certain appointments are still pending, the plan for the nursing personnel of the national and branch offices has been settled. In the National Office there will be the same national directors as formerly, Miss Noyes, Director of Nursing Service, Mrs. Baker, Director of Home Hygiene and Care of the Sick Instruction, and the writer, Director of the Public Health Nursing Service. Miss Noyes and Mrs. Baker will have assistants and in the Public Health Nursing Service there will be an Assistant National Director, Miss Teal, assisting with the research and educational work of the Service, and another Assistant National Director, Miss Havey, in charge of the direction and supervision of the chapter public health nursing services in the area covered by National Headquarters. Miss Havey will have two assistants, Miss Annabelle Petersen and Miss Myrtie Taylor, formerly nursing field representative in New Jersey.

In the St. Louis National Branch Office there will be an Assistant National Director of Nursing, Mrs. Vaughan, who will have Miss Rose Ehrenfeld as Assistant, and a Director of Home Hygiene Instruction. Miss Chapman is generously remaining until early summer to assist in the necessary adjustments. Miss Witchen, formerly Mrs. Vaughan's assistant in the Central Division, though not desiring an office position, may remain with the Red Cross in the field. Miss Yerkes has taken a position with the Webb Publishing Company in St. Paul.

In the San Francisco National Branch Office, Miss Ledyard will continue as Assistant National Director of Nursing for the area formerly covered by the Pacific Division.

All the personnel of the nursing field staff is being retained and others will be added. Several changes in territory are being arranged but are not yet finally concluded. Announcement of these changes will be given in a later issue.

E. G. F.

REVIEWS AND BOOK NOTES

SANOCRYSIN

"Is This a Cure for Tuberculosis?" is the title of an article by Dr. Haven Emerson in the *Survey Graphic* for February. Sanocrysin, a salt of gold which is said to cure tuberculosis, is the theme of Dr. Emerson's paper. This discovery of a Danish physician, Dr. Holger Moellgard, is also the subject of an editorial in the February number of the *American Journal of Public Health*, which reviews the experiments with sanocrysin and concludes, "we can only advise watchful waiting and the cultivation of a frame of mind which will not leave us despondent if this alleged cure meets the fate of all its predecessors." And the *Journal of the Outdoor Life* for February, in an article reviewing the romantic history of the use of gold in medicine from the days of the Caliphate of Bagdad to the present, also considers this most recent experiment in the use of gold in tuberculosis. Those who are interested in this latest attempt to conquer tuberculosis will find a full and clear treatment of sanocrysin in these three magazines.

As Dr. Emerson says, "here is a chance for chemistry to establish itself as the great savior—as it has so recently been hailed as the arch destroyer—of mankind." Whether or not victory is within the grasp of the chemotherapists, there is pure drama in the possibility that gold, the precious metal for which man has fought and agonized through the ages, may yet prove to many the "elixir of life" it was believed to be centuries ago.

The Sixth Annual Report of the Commonwealth Fund has just been issued. The Report presents an imposing array of achievements in this country and abroad, especially in the field of child welfare. The programs of The Child Health Demonstrations in Fargo, North Dakota, Athens, Georgia, and Rutherford, Tennessee, are described, and "Some Problems and Their Solution," especially in regard to expenditure and per capita cost, are taken up in a manner which will interest all concerned with these practical points of administration.

The Child Guidance work of the Commonwealth Fund is also interestingly described. The part of the report dealing with their program in Austria will be taken up in our next number.

A most interesting and suggestive report. It can be had on request from the Commonwealth Fund, 1 East 57th Street, New York City.

Do you want to know just what the N. O. P. H. N. is? And why? And what it has been doing? And what it is going to do? If you do, we have a little booklet called *"Inside Information"* which will give you just that. We should be glad to send you a copy.

The Twelfth Annual Report of the Chief of the Children's Bureau has just been published and shows a formidable list of accomplishments in connection with its various divisions with their wide and diverse activities. An account of children's work on truck farms of the northern Pacific coast is especially interesting to us—editorially speaking—because of the article on "Public Health Nursing in Hop Yards" which appeared in January. A summary of State Child Welfare Agitation obtained by the Bureau is given in the Report. During the fiscal year 37 new and revised publications were issued by the Bureau.

The Committee on Drug Addictions of the Bureau of Social Hygiene, Inc., coöperation with the United States Public Health Service and the Narcotic Division of the Bureau of Internal Revenue, has published in pamphlet form a *Preliminary Report on Studies of the Use of Narcotics under the Provisions of the Federal Law in Six Communities.* Six communities representing as nearly as possible all factors contributing to a varying use of these drugs were selected. These studies were made with the hope of determining the amount of opium and coca leaves required to meet the legitimate needs of the United States for a twelve month period. Also,

to make available for use by the international conference called on invitation by the League of Nations data which might prove valuable as a basis of fact for estimates made in a consideration of the limitation of the production of the drugs concerned.

Copies of the report can be obtained from Charles E. Terry, M.D., Executive of the Committee, 370 Seventh Ave., New York City.

Health book month, sponsored by the National Health Council and the National Association of Book Publishers, is scheduled for April. The slogan adopted is "Through Health to Happiness, Find It in Books." Books on health and outdoor life will be the theme of newspaper and magazine articles, and special exhibits of books on health subjects will be held in public libraries, schools, clubs and bookstores. In many cities a "health evening" will be held in the public library with timely addresses. Schools also will participate, with health talks and loan exhibits. New books will be added to many school libraries, based on the list recommended by the American Child Health Association. The National Health Council Library has two book lists, *Popular Books on Health* and *Health Books for the Family.* The Bureau of Education, Washington, D. C., publishes a reading list for parents, *Pathways to Health,* price 5 cents.

In that perfectly enchanting and delicious and diverting book of verse, *When We Were Very Young,* by A. A. Milne, we find "The Doormouse and the Doctor." We need not say why we especially print these selections. Alas, it is too long to print in full.

There was once a Dormouse who lived in a bed
Of delphiniums (blue) and geraniums (red),
And all the day long he'd a wonderful view
Of geraniums (red) and delphiniums (blue).

A Doctor came hurrying round, and he said:
"Tut-tut, I am sorry to find you in bed.
Just say 'Ninety-nine,' while I look at your chest.
Don't you find that chrysanthemums answer the best?"

The Doctor stood frowning and shaking his head,
And he took up his shiny silk hat as he said:
"What the patient requires is a change," and he went
To see some chrysanthemum people in Kent.

The Dormouse lay there, and he gazed at the view
Of geraniums (red) and delphiniums (blue),
And he knew there was nothing he wanted instead
Of delphiniums (blue) and geraniums (red).

The Doctor came back and, to show what he meant,
He had brought some chrysanthemum cuttings from Kent,
"Now these," he remarked, "give a much better view
Than geraniums (red) and delphiniums (blue)."

The Dormouse looked out, and he said with a sigh:
"I suppose all these people know better than I.
It was silly, perhaps, but I did like the view
Of geraniums (red) and delphiniums (blue)."

The Doctor returned, ordered him "Nourishment, Tonic and Rest" and said "How very effective all these chrysanthemums look!"

The Dormouse turned over to shut out the sight
Of the endless chrysanthemums (yellow and white).

The Dormouse lay there with his paws to his eyes,
And imagined himself such a pleasant surprise:
"I'll pretend the chrysanthemums turn to a bed
Of delphiniums (blue) and geraniums (red)!"

Next morning the Doctor rubbing his hands said cheerfully:

"There's nobody quite understands
These cases as I do! The cure has begun!
How fresh the chrysanthemums look in the sun!"

The Dormouse lay happy, his eyes were so tight
He could see no chrysanthemums, yellow or white,
And all that he felt at the back of his head
Were delphiniums (blue) and geraniums (red).

CHILD HEALTH LIBRARY

Edited by John C. Gebhart. Introduction by Haven Emerson, M.D.

Robert K. Haas, Inc., New York. Price, $3.00.

Pre-Natal Care and the Baby's Health, by Harbeck Halstead, M.D.
Babies—Their Feeding and Care, by Louis C. Schroeder, M.D.
The Neglected Age—The Child from Two to Six, by B. S. Denzer, M.D.
Dangers of the School Age, by M. Alice Asserson, M.D.
Communicable Diseases of Childhood, by Stafford McLean, M.D.
Hygiene of the Mouth and Teeth, by Thaddeus P. Hyatt, D.D.S.
What Children of Various Ages Should Eat, by Lucy H. Gillett, M.A.
How Children Ought to Grow, by John C. Gebhart.
Psychology of the Child, by David Mitchell, Ph.D.
Educational Problems, by David Mitchell, Ph.D.

This series of small books (the size of the "Little Leather Library" books) must not be confounded with the *National Health Series* prepared by the National Health Council and published by Funk & Wagnall.

As will be seen by the titles, these little volumes have been prepared by a group of eminent pediatrists and social workers. They take up various phases of chily hygiene in popular but scientific form for parents. They also provide, as Dr. Emerson says, "not in forbidding terms, but in the helpful language of understanding friends," a great deal that everyone concerned with the care and upbringing of that important personage, "the child," has to pass on—perhaps not in such "helpful language"—every day and all days.

An attractive set of book ends is included with the volumes.

Nurses will be interested to know that the National Federation of Day Nurseries, 105 East 22d Street, New York City, is now publishing a monthly bulletin.

The *Illinois Arrow,* published by the Illinois Tuberculosis Association, devotes its February number largely to reports and brief articles of public health nursing services. It is always cheering to see ourselves really appreciated and the *Arrow* has said some pleasant things.

It reminds the public that "Wherever the Public Health Nurse Is, the Death Rate Goes Down and the Health Rate Goes Up." Also that "The Community Nurse is not an expense. She is an investment." A brief history of the development of public health nursing in Illinois gives interesting facts. Mrs. Elsbeth Vaughn gives "A Periodic Analysis of Public Health Nursing Services" and Miss Spaeth an account of "Early Illinois Experiences," in which she says:

> So much depends on the nurse in the field. Most of us are afraid of our own voices, and make every effort to be excused from speaking in public instead of courting invitations. There is nothing that can so quickly kill a nursing service as lack of publicity with reference to the nurse's work.

The Bureau of Child Hygiene of the Texas State Board of Health has published a report on the survey of the midwife situation in Texas. The startling information on the conditions found more than justifies the hope expressed by the Director of the Bureau that the report "should arouse all thinking people to the dire need of remedial action without delay." Miss Katherine Hagquist, R.N., Supervisor of Midwife Control Measures, who made the survey, concludes her graphic account with a quotation from Peter Chamberlain, the younger, written in 1646, when he implored for instruction and supervision of English midwives:

> Because multitudes have perished, therefore must they still perish?
>
> Because our forefathers have provided no remedy, nor knew any, therefore must we provide none, though we know it?

England has very thoroughly provided a remedy. So will Texas.

NEWS NOTES

Rebecca Shatz, who for some years has been Associate Director of the Visiting Nurse Service of the Henry Street Settlement, has resigned. Miss Shatz was one of the very earliest of the small group who joined Miss Wald when the Settlement began its remarkable career in a few rooms in a tenement in Henry Street. For almost thirty years Miss Shatz has given devoted and loyal service to the development of the work of both the settlement and the nursing staff. These years of practically uninterrupted service make up one of those intangible and far-reaching additions to the sum of our groping efforts towards a wider humanitarianism which can never be reduced to cold statistical facts. Only her many and widely distributed friends who know the whole-hearted devotion which Miss Shatz during all these years has put into her work at Henry Street can gauge her gift to public health nursing. Miss Shatz is going for a time to one of those warm, dry Western States which sound so attractive at this time of the year to Easterners. Our good wishes go with her.

Miss Elizabeth Mackenzie recently assumed the duties of Associate Director of the Henry Street Nursing Service, the position formerly held by Miss Shatz. Miss Mackenzie, who is a Canadian, was formerly assistant director of nursing of the Alabama state department of health.

Miss Ella P. Crandall has sent in her resignation to the American Child Health Association.

When the American Child Hygiene Association and the Child Health Organization of America came together in 1923 with Mr. Courtenay Dinwiddie as General Executive, Miss Crandall was appointed as Associate General Executive. During the difficult period of getting together two organizations and remoulding their separate pieces of work into a new form, Miss Crandall's experience and power of maintaining a gracious equilibrium proved invaluable.

The preliminary period of readjustment is past, and with Mr. Dinwiddie's resignation and reappointment as the Director of the Child Health Demonstration Committee affiliated with the American Child Health Association for the supervision of the Commonwealth Fund Child Health Demonstration Program the new General Executive is relieved of the direction of the Demonstrations. The position of an Associate Director is now no longer necessary.

All the members of the N.O.P.H.N. staff will deeply regret losing the close contact with Miss Crandall we have been privileged to have during these two years. We, together with her hosts of friends, wish her the continued happiness of successful work.

Miss Marie T. Lockwood, State Board of Health, Dover, Delaware, has been appointed Secretary of the Child Welfare Section of the N.O.P.H.N.

Miss Virginia M. Gibbes has accepted the position of Director of Nursing, under the City Welfare Commission of Knoxville, Tennessee. Miss Gibbes was with the American Red Cross during a period of years, including service in the Philippines as the Director of Nursing Activities.

Miss Freda Johnson, formerly New York state representative of the American Red Cross, sailed February 14 for Rio de Janeiro, Brazil, where she will work with Mrs. Ethel Parsons, general superintendent of the Nursing Service of the Department of Public Health. Miss Johnson will have charge of the public health nursing field work.

The headquarters of the Nurses Association of China were moved from Shanghai to Hankow January 1.

Miss Helen V. Stevens, formerly a supervisor with the Henry Street Visiting Nurse Service, and more recently supervisor of instruction of the Minneapolis Visiting Nurse Association, has been made associate director with Miss Nan Dorsey of the Pittsburgh Public Health Nursing Association.

The Michigan Board of Registration of Nurses and Trained Attendants will hold an examination for graduate nurses and trained attendants in Lansing, Michigan, March 11 and 12, 1925.

A teaching center for nurses has been established in Montreal by the Metropolitan Life Insurance Company in coöperation with the University of Montreal, the Province of Quebec, the city of Montreal and the Anti-Tuberculosis and General Health League. The school has been organized particularly for the benefit of French-Canadian nurses. The Metropolitan is providing the Nursing Director and two assistant nursing supervisors. Miss Edith B. Hurley has been named director of the center. Miss Hurley, who holds the degrees of A.B. and M.A., and taught school before entering training, has had practical field experience and has served as supervisor and Director of the Morningside Center with the Henry Street Nursing Service in New York.

An international poster competition has been organized by the League of Red Cross Societies, to supply the National Red Cross Societies with posters giving an adequate idea of the humanitarian work of the Red Cross in peace time. This work includes "the improvement of health, the prevention of disease, and the mitigation of suffering throughout the world." The League appeals to artists throughout the world to make this competition a universal art tribute to the work of the Red Cross. One prize of 5,000 francs is to be awarded by a majority vote of the jury to the designer of the poster considered to be the best. Other noteworthy posters will be bought upon the advice of the jury, and 500 francs will be paid for each poster chosen. The designs submitted must be capable of reproduction as "double Colombier" posters. Artists wishing to take part in this competition are requested to send their names to the Secretariat of the League by April 1, and the posters should reach the Secretariat at 2, Avenue Velasquez, Paris, France, by May 31.

The 1925 annual convention of the National League of Nursing Education will be held this year in Minneapolis, Minnesota, May 25 to May 30.

The second annual conference of the International Catholic Guild of Nurses will be held in Spring Bank, Okauchee, Wisconsin, headquarters of the Catholic Hospital Association, May 31–June 6. An opportunity will be given nurses to spend a second week of recreation and sociability after the general program is over. The lake affords fishing, swimming and boating, and the grounds offer ample opportunity for walks and athletic sports. Negotiations are now on foot to secure Spring Bank in trust for the use of the Catholic Hospital Association conferences and the meetings of the Guild. Due to the additional financial burden involved in the purchase, it will be necessary to charge $3.50 a day for accommodations instead of $3.00 as last year.

The conference will begin with three days of spiritual exercises, the annual retreat of the Guild, to be followed by the business meeting and the discussion of the general subject of the conference, "Nursing Opportunities," by graduate nurses of experience in various fields of nursing.

Nurses wishing to make sure of reservations should write as soon as possible to the Guild at 124 Thirteenth street, Milwaukee, Wisconsin. It

would be well to send at the same time a deposit of $5.00 to ensure the holding of a place.

Nursing supervisors from all parts of the United States and Canada attended the annual convention of the Metropolitan Life Insurance Company January 26-February 2, discussing mutual problems and planning the work of the coming year. As the nursing service of the Metropolitan is an integral part of its Welfare Division, the first day's program consisted of a general survey of the work of the whole division, with emphasis on the part played by the Nursing Section. This service reported 2,565,295 visits made to 543,753 patients.

Dr. Louis I. Dublin presented a statistical report of the welfare work and expressed the hope that a tremendous effort would be made this year to campaign against diphtheria and smallpox. Dr. Lee K. Frankel, director of the division, said that an effort would be made to influence all parents to have their children inoculated against diphtheria and vaccinated against smallpox.

A delightful luncheon was given during the convention with Mrs. Marion T. Brockway, House Mother of the Metropolitan, and Mrs. Helen C. La Malle, Director of the Nursing Service, as hostesses. The guests included representatives from a number of the prominent nursing services in New York City. Mr. Haley Fiske, president of the company, expressed his gratitude for the remarkable service rendered by the nurses. Dr. Frankel announced plans for increased nursing activity. Mrs. La Malle in a delightful introductory speech announced the "nurse speakers" for the occasion. Three staff supervisors were also on the program. They were Miss Mary Horn, local supervisor in St. Paul, who spoke on the value and importance of local supervision; Miss Carolyn Hidden, supervisor of the Middle Atlantic territory, who dwelt on the need of closer contact with staff nurses and the importance of making them realize their opportunities and responsibilities; Miss Ruth Waterbury, Group Nursing Supervisor, gave an interesting account of her contacts with the many industries she has visited and spoke especially of the generous response from employers desirous of carrying an effective health program. Miss Hazel Corbin, director of the Maternity Center Association, and Miss Ada M. Carr, editor of THE PUBLIC HEALTH NURSE, also spoke briefly.

On February 12, the Alumnae of the Department of Nursing Education of Teachers College (formerly the Department of Nursing and Health) held its annual reunion.

The day's meetings discussed the general subject, "Adjustments in the Nursing School Curriculum." Dr. Snedden's topic was "Job Analysis or the Basis for Curriculum Making." Dr. Snedden feels that the sound basis upon which to build up a curriculum is through a study and analysis of the job itself. He emphasized the fact that we must not only study the needs of the job but also the practical question of the capacities of those who are to be the workers in any field, keeping in mind the fact that a hand "full of trumps" cannot represent the average workers in any field.

In discussing the question, "What is Public Health Nursing?" Miss Anne Stevens brought out the qualifications for public health nursing in terms of character, knowledge, skill and attitudes required of the nurse in public health. She indicated that the qualifications needed for public health work were fundamentally those needed for the best type of nursing work in other fields. Miss Stevens stated at the same time that special preparation for public health work was of course essential.

Miss Taylor and Miss Grant, from the Yale School of Nursing, discussed "To What Extent Can the Fundamental Principles of Public Health Nursing Be Included in the Under-Graduate Curriculum?" Their discussion was based upon the development of the curriculum at the Yale School.